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Supreme Court, U.S.
FILED

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No.

OFFICE OF THE CLERK

Supreme Court of the United States
1st Street N.E. DC 20543-Clerk Office
202-479-3011

Joseph S. Maresca- Petitioner-Pro Se

versus

Dr. Elliot L Mancall MD Respondents
Thomas Jefferson University Hospital

On Petition for a Writ of Certiorari

To the Court of Appeals 3rd Circuit: 04-3103
(Rendell, Fuentes, Opinion by Garth
on 6-8-05 ;issued 6-16-05
Reconsideration Denial 12-19-05; Writ Due 3-20-06)

Joseph S. Maresca-Pro Se- PETITIONER
Of Record
Bronxville, NY 10708-0646
914-649-3817

RESPONDENTS

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BOOK I OF II

QUESTIONS PRESENTED

Petitioner (Pro-Se), Joseph S. Maresca visited Dr.Mancall MD on 12-5-96 at age 44. An unknown medical student took the medical history in the outpatient clinic of Thomas Jeff. Univ. Hosp, Inc. He complained to both of a pulling of the facial mask, difficulty in typing & musculoskeletal limitations. Dr.Mancall ordered & the patient had a brain MRI showing cerebellar atrophy. The medical record showed a partially implemented plan with no monitoring. "Plan MRI. If OK, Fiorinal. return post-MRI". On 9-8-99, Dr.Waterman Rheum of UCONN ordered back x-rays showing Ankylosing Spondylitis. Diplomate Felder MD-Neurologist testified to the mis-diagnosis and non-monitoring of the patient in a multiple dependant trial exam incorporating the testimonies of Dipl. Deng-Acupuncturist, John Waterman MD-Rheumatologist, Dr.Mancall (defendant) and the plaintiff. A28-160 The DC Trial Court dismissed the action after closure of the Plaintiff's Case in Chief without "reserving judgment" in a Civil Rule 50 as a Matter of Law . Questions Presented Are:

1. Whether the DC Trial Court & 3rd Cir. Appeals applied the Civil Rule 50 as a Matter of Law properly despite 323(a) Restatement Torts at EADDY 694 A2nd at 642 BILLMAN ?
2. Whether an incurable but treatable bone disease Ankylosing Spondylitis is protected by the Pennsylvania statutes and whether or not MINE-SSA DI 280. 40.001 & the 5th Cir. 95-60433 conflict with the Pennsylvania Law , MCARE & the DC and 3rd Circuit opinions in this case? Trial A 28-165
3. Whether a Manifest Injustice accrues to Ankylosing Spondylitis patients & others; i.e. late stage Tay Sachs on incurability and patient's 1st, 7th, 11th ,14th & 21st amendment rights & protection from local practice limits by Felder v. Casey all abridged by lack of clarity in Brophy v. Brizuela OBVIOUSNESS criteria or Metzelfelt UNOBVIOUS disease criteria?
4. Whether or not the Fed Register Vol. 63 #35 issue 2-23-98 P. 8990 applied to the Thomas Jefferson Univ. Hospital Inc; such that a compliance officer required by statute would have mitigated Petitioner's damages .The Trial Court should have "reserved judgment" and considered "systemic negligence" .
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A.133 Pathology report of Dr.Dworkin MD-Surgeon findings of Crohns 12-20-91 noted in Dr.Mancall's encounter form 12-5-96

A.134 Article on Mortality Among Patients with Ankylosing Spondylitis Not Given X-ray Treatment VOL. 297 7: 572-7 9-15-77 New England Journal of Medicine cited as per Civil Rule 803.18 with attributions to other authors citing this article

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DC Court Approved Trial Exhibits-Unobjected

SUPREME COURT APP.	DC TRIAL COURT APPROVED EXH.
A115-128	Trial Exh.43-53 and 55 for Dr.Mancall
A39-43	Trial Exh. 1-40 Diplomate Deng-Acupunc.
A67-A69 A79-A83	Trial Exh. 71-3 , 89 and 300 Dr.Kellman
A66-A71	Trial Exh. 91-96 Dr. Waterman MD-Rheumatologist
A156-A160	Trial Exh. 97-100 for Dr.Lee MD Physiatrist
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A135-143	Expert Letter of Diplomate Felder MD Neurologist and Psychiatrist Trial Exh. 142-145 under advisement until conclusion of Defendants Cases in Chief
A133	Trial Exh. 117 Colonoscopy of Dr.Dworkin finding Crohns Disease - Exhibit taken under advisement
A.55-6	Thomas Jefferson Univ, Hospital,Inc. corporate charter (excerpts) filed with Pa. Sec'y of State (excerpts for the Jefferson Medical College)
A131-2	Trial Exh. 135-6 of Dr.Abel MD Encounter form referral to Rheum.

Cited Authorities

1. Section 323a of the Restatement of Torts (Second) , Eaddy 694 A 2nd at 642 ; Billman 781 A 2nd at 1212-13 cites the risk of harm as the dispositive criteria for overcoming a Rule 50 Motion as a Matter of Law.

" Accordingly, if a plaintiff has proven that the physician's breach increased the risk of harm, then there is sufficient evidence to overcome a Motion as a Matter of Law. The expert in cases of this nature has been permitted to testify under the relaxed degree of certainty enunciated in Sec. 323a of the Restatement (Second of Torts), that the defendant's failure to exercise reasonable care in the diagnosis and treatment was a substantial factor that increased the risk of harm. "

2. Citation which conflicts with the decision on this case:

"He was diagnosed as suffering from Ankylosing Spondylitis, a chronic, progressive and debilitating disease which fuses the spine and causes rigidity of the cervical, thoracic and lumbar vertebrae."

Smith v. United States Railroad Retirement Board 95-60433 United States Court of Appeals 5th Circuit by Chief Politiz, Davis, Garza

This case defines Ankylosing Spondylitis, its major manifestations and causal elements.

3. There is an exception from the governing precedents of the medical malpractice law in Pennsylvania when:

"The matter is so simple and the lack of skill or want of care is so obvious as to be within the comprehension of a non-professional person(s) "
Brophy v, Brizuela 358 Pa. Super 400, 405, 517 A 2nd 1293, 1296 (1986)

4. Under applicat ennsylvania law, professional negligence in the nature of medical malpractice consists of the following:Pa. Stat. Ann. tit. 40 Par 1303.512 LEX'03

1) a duty owed to the plaintiff
2) a breach of the duty by a physician or institution
3) a causal connection with plaintiff's harm
4) a direct link between the harm and plaintiff's damages

Mitzelfelt v. Kamrin 526 Pa. 54, 62 , 584 A 2nd 888,891(1990)

[The law doesn't say that the physician must cure the patient or that incurable but highly treatable diseases aren't protected.]

5. Rule 60 (b)(2) provides:

" The question therefore, is whether a general rule of law applicable to many cases is desirable and feasible, or whether to rely on more flexible ad hoc judgments. If an issue is one of law, appeal can be taken in every case where that issue is presented in a context slightly different from those for the precedents on that issue. In its decision the Appeals Court must make reference to the fact that the District Court ruling was not sustained by the evidence. "

6. Rule 52 does not inhibit the Appellate Court from correcting errors of law.

Ct. at 1530 89L Ed. 744-749

7. Mixed questions involve whether or not the rule of law as applied to the established facts is or is not violated.

456 U.S. at 289 *n* 19 102 S. Ct. at 1790 *n.* 19 475 U.S. at 714 106S Pa. R. Civ. P. 1042.3

8. Assuming a literal application of the Pennsylvania law under the Mitzelfelt criteria, would a manifest injustice accrue due to the actions of the Trial Court?

Roberts v. Madigan 921 F 2nd 875, 9th Circuit, 10th Cir.'90
Cale v. Johnson 861 F 2nd 943, 947, 6th 1988
Arizona v. Cal. 460 U.S. 605 1983

9. The medical malpractice statute in Pennsylvania does not accrue until the plaintiff discovers or reasonably should have discovered that the physician failed to diagnose and treat him/her ; such that, the failure is a causal factor in the injury. On the basis of this precedent, plaintiff's Summary Judgment was granted by The Honorable Legrome D. Davis. 6-20-03.

[DC Docket #47]

Hughs v. U.S. 263 F. 3rd 272, 276-7, 3rd Circuit 2001

10. A hospital may be held liable under the theory of corporate negligence. Under this theory of liability, a non-delegable duty is created which the hospital owes directly to the patient and the injured party doesn't have to rely on or establish 3rd party negligence. This has been delegated thusly into 4 categories:Pa. Stat. Ann. tit. 40 Par 1303.516 LEXIS 2003:

1) a duty to use reasonable care in maintaining safe and adequate facilities and equipment
2) a duty to select and retain only competent physicians
3) a duty to oversee all persons who practice medicine within its walls as to patient care
4) a duty to formulate, adopt and enforce adequate rules and policies to enforce patient care.

Thompson v. Nason Hosp. 527 Pa 330-591 A 2nd 703 1991 1d at 339-40 591 A 2nd at 707

11. Neglectful inaction rather than a specific act itself by hospital employees will trigger liability.

Moser v. Heistrand 545 Pa 554, 560, 581, 681 A 2nd 1322, 1329, 1996

12. The Parol Evidence Rule may be involved to clarify an ambiguity; such as an entry which is on the encounter form or one that should be there. It may be utilized to establish bad faith, to resolve an error conclusively or to establish error.

Ref. Thomas Jefferson University Hospital encounter form 12-5-96 Expert Letter of Diplomate Felder MD-Neurologist A. 76-79

13. The following parts deal with patient medical records preparation in form and content.

"A patient's medical records shall be complete, readily accessible and available to the professional staff concerned with the care and treatment of the patient."
28 Pa Code 115.31 (2b)

"A physician shall maintain medical records for patients which accurately, legibly and completely reflect the evaluation and treatment of the patient."
49 Pa Code 16.95

"A patient's medical records shall be retained by a physician for at least 7 years from the date of the last medical service for which a medical record entry is required."
49 Pa. Code 16.95(e)

"The medical record shall contain information sufficient to clearly identify the patient. The person making the entry , if not the physician, such as a physician assistant, the date of the medical entry and patient complaints and symptoms should be noted. " 49 Pa Code 16.95(e)

14. The following part deals with the requirement for compliance reviews and a compliance officer to monitor teaching physicians and residents in teaching facilities; such as, Jefferson Medical Col.
"FR Vol. 63 #35 MONDAY 2-23-98 Fed.Register Pg.8990"

15. 28 Pa Par 115.34 requires a medical records review by the medical records committee for completeness including a system for disciplinary action and requires that recorded clinical information be sufficient for medical care evaluation.

16. The Pennsylvania Medical Board Sec. 11e requires that notes made on patient's charts by a clinical clerk (medical student) become official only when counter-signed by a medical doctor or member of the hospital medical staff or resident beyond a first year level of graduate medical education at the hospital.

17. This is a dispute between a citizen of New York-the Plaintiff, Dr. Mancall MD who resides in New Jersey and the institution of Thomas Jefferson in Philadelphia. The appeal very importantly separates law and facts gleaned from the multiply dependant expert testimony and the myriad of fact witness testimony that supports the expert witness includes the Trial Exam of the plaintiff/appellant, Diplomate Deng-acupuncturist, Dr. John R. Waterman MD-Rheumatologist, Diplomate Felder MD-Neurologist, Dr.Kellman MD and Dr. Lee MD, PhD - treating physicians. The 14th Amendment protects clearly the medical rights of the Plaintiff/Appellant because no state can enforce laws which constructively-in their implementation abridge a citizen's constitutional rights. The Court is asked to weigh state powers over the rights of the individual. Lastly, the government has issued a mandate requiring medical school institutions and their related hospitals to engage a compliance official and do periodic audit reviews. The 11th amendment places this issue in the State courts or Court of Common Pleas. DC docket 1-6.

This mandate predates by a year and one half, the reasonable 9-15-99 discovery of ankylosing spondylitis by Dr. Waterman MD-Rheumatologist at UCONN.

18. A new MCARE fund limitations for 2006 are $750,000/ $2.25MM for physicians and $750,000/$3.75MM for hospitals. Pa.Stat.Ann.tit.40 Par 1303.714,715 (LEX '03)

19. Constitutional Amendments:

FIRST- Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of people peaceably to assemble; and to petition the Government for a redress of grievances.

SEVENTH- In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury, shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law.

FOURTEENTH-SECTION I- All persons born or naturalized in the U.S., and subject to the jurisdiction thereof, are citizens of the United States and of the State where they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of any citizens of the United States; nor shall any State deprive any person of life, liberty or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

The petition for redressing grievances and provisions of the 14th amendment dealing with due process and equal protection were first referenced in the DC docket 12- "Complaint", DC docket 38 Opposition to Summary Judgment, DC dockets 44, 45 containing the Petitioner's Opposition to DEFENDANT's Summary Judgments, Rule 50 Argtument at Trial DC docket 85, Petitioner's Request for Reconsideration of the Court's 5-7-04 finding for Defendants as a Matter of Law-DC Doc 87

Essentially, the medical malpractice deprived the Petitioner of life, liberty and property for the period from 12-5-96 to 9/1999 and during the exhaustive pendency of this case in the Courts.
[3 years non-diagnosis and 5 years in litigation]
20. The Supreme Court has interpreted the common law in the 7th Amendment to be the apotheosis of the English Common Law as it existed in 1791.

Dimick v. Schiedt 293 U.S. 474, 496-7 (1935)
Markman v. Westview Instruments 517 U.S. 370, 376, 196 quote Balt. and Carolina, Inc. v. Redman 295 U.S. 694 (1935)

Generally, a jury is the independent check on the power of the Judiciary. A jury alone can determine damages.

Thomas, Remittitur, supra note 27 at 770 and 794

When given the option of a new trial or remittitur in 71% of cases, plaintiffs took remittitur or settled the case. It is indisputable historical precedent that the role of the jury is a decision-maker on damages and the Constitutional text supports this role in the 7th Amendment. The 11th amendment places the issue in the Common Plea Court.
21. The DC Court considered a Civil Rule 50 Motion as a Matter of Law at the beginning of the trial and denied the Defendants. The Motion was issued again at the closure of Plaintiff/Petitioner's Case in Chief. The DC Court should have "reserved judgment" to gain perspective on the contrasting presentations. In addition, the DC Court caused the presentation to be highly abbreviated by requesting that parties limit the trial to 3 weeks. Since the Petitioner presented his witnesses and agreed to depose the defendant and the defendants' experts in the Defendants' Cases in Chief, the DC Court should have "reserved judgment" after having gained the cooperation of the Petitioner in limiting trial presentation time by not examining the defendant or the defendants' experts in the Plaintiff's Case in Chief.

21. On 10-22-01, the case was removed from the Court of Common Pleas in Philadelphia to the District Court for Eastern Pennsylvania 01-5355 for assignment to the Honorable Schiller. The defendants' legal rationale was the existence of "diversity " only.

The plaintiff issued a Motion explaining that the case belonged in the Philadelphia court because the local jurisdiction was more familiar with the local law and practices. The defendants moved the case from Common Pleas to the federal jurisdiction because juries tend to make higher awards to plaintiffs in Philadelphia.

The juries are selected statewide in the federal jurisdiction and awards are slightly lower as a result of the statewide diversity in the jury selection itself. Constructively, insurers save money by litigating in the federal jurisdiction because the Philadelphia jury awards are approximately $100,000 to $150,000 higher than federally.

DC Docket 1-6, DC Docket 7-transfer of the record

Although insurers save money by paying lower awards federally, the federal court system is burdened with extra cases which belong in the State courts or the local Court of Common Pleas in Philadelphia.

In addition, Metzelfelt is murky. It does not explain how to apply obviousness and unobviousness criteria uniformly. Resultingly, jurists are free to write new medical law. Felder v. Casey, 487, U.S. 131, 138 '88 was decided by this Court to protect the rights of individuals from encroachment by local practice customs and laws which effectively remove the rights enunciated in the 1st, 7th, 11th and 14th amendments to the Constitution.

Parties Whose Judgment Sought for Review (Items 1-3)

The parties whose judgment is sought are:
1. Appellate Court 3rd Cir.-Case 04-3103
The Honorables Rendell, Fuentes and Garth
Petition to Rehear Denial - The Honorable Rendell
Order entered 12-19-05: Petition filed on Appellate
Docket Entry #48

Order Affirming a DC Court of Eastern Pennsylvania
finding for the Defendants on a Matter of Law by the
entered on 6-16-2005 by
Honorables Rendell, Fuentes, Garth-Opinion Issuer)
Judgment Order on Appellate Docket # 42;
Docket Opened #1; Brief of Appellant Filed #19;
Proposed Amicus Curiae Brief by Diplomate Deng #22;
Clerk Order Referring Case to a Merit Panel#23
Basis: Sec 323(a) Restatement (Second of Torts);
Parol Evidence Rule Applicable to the Expert Letter of
Diplomate Felder MD-Neurologist,Psychiatrist and all
fact testimony by video presentation at trial and trial
transcript of Dr.John R. Waterman MD 5-4-04; the personal
testimony of Diplomate Deng-Acupuncturist at trial on
5-4-04; the Amicus Curiae Brief of Diplomate Deng and
the fact testimony of the treating physician Dr.Kellman MD-
Internist by Video and trial transcript 5-4-04.

Lack of clarity regarding how to apply the causal connection
between the physician's harm and the plaintiff's damages.
i.e. scintilla of evidence standard, grey area or reasonable
person standard.

The institution of Thomas Jefferson University Hospital,Inc.
is not in compliance with Federal law-FR Vol.63 #35;
2-23-98; P. 8990 requiring a Compliance Officer; such that,
Petitioner's claim may have been halved with compliance
federally. Discovery Denial-DC Docket 26 of 11-12-02.

2. Rule 50 Order in Favor of Defendants at Conclusion of the Plaintiff's Case in Chief by the Honorable Legrome D. Davis of the District Court of Eastern Pennsylvania

[DC Docket 86 on 5-10-04]

Reconsideration Denial Due to the Filing in the Appellate Court Taking the Case Out of the District Court Without Prejudice 8-30-04

3. The 11-19-02 Denial of Plaintiff's Motion for Remand should be reviewed because the in depth knowledge of the medical malpractice law is in the Court of Common Pleas, Philadelphia. Docket #6 by Honorable Schiller

Basis: The DC Court should have reserved judgment to allow a full discussion of the evidence and the expert letters. In addition, the Court did not give sufficient consideration to Sec. 323a-Restatement of (Second)Torts which relies on the physician failure to exercise reasonable care in the diagnosis as a condition precedent for continuing the trial. In addition, the Trial Court mis-interpreted the causality of the disease Ankylosing Spondylitis with Metzelfelt's requirement for a causal connection between the harm arising from the physician negligence with the accompanying pain, suffering and quality of life issues for the patient.

Eaddy 694 A. 2nd at 642 cites Billman 761 A.2nd at 1212-1213

In addition, SSA DI 280 40.001 MINE Sec. 416.99c is the governing law on the definition and treatment of Ankylosing Spondylitis. The law defines this as a MINE disease. Medical Improvement Not Indicated is the classification. MINE relegates the claim to treatment of symptomatology explained by Diplomate Felder MD-Neurologist. A.113 p.110

The case was moved from the Court of Common Pleas-a Court in the Commonwealth of Pennsylvania into the federal jurisdiction under the guise of "diversity" of the parties to the litigation. This action on the DC Docket#1-6 violates the spirit of the 11th Amendment to the Constitution which exists to prevent citizens from different states from arguing in the federal courts. The initial ruling which placed this case in the federal jurisdiction was affirmed by the Honorable Judge Schiller of the DC -Eastern Pennsylvania.

The defendants filed Motions in Limine to preclude the testimony of the plaintiff's physician witnesses in the overall presentation. Metzelfelt does not require setting aside the testimony of all physician witnesses except for the expert witness and Brophy v. Brizuela allows all testimony (expert or non-expert) if the medical presentation is or would be obvious to a non-practitioner in the art to which the plaintiff's claim applies. Therefore, the Motions in Limine would not apply to the testimony under the Brophy v. Brizuela criteria. It is unclear whether or not the Metzelfelt criteria bars "fact witness" testimony. Besides the Motion in Limine does not apply since the expert witness has incorporated by reference the depositions of Dr.Mancall, Diplomate Deng and the Rheumatologist-Dr.Waterman MD of UCONN.

[DC Docket 59, 64,70,72]

In addition, Dr.Waterman MD-Rheumatologist indicated that the legal counsel of the Veteran's Administration Hosp. barred him from providing expert trial testimony. The Supreme Court is asked to view the testimony of Dr.Waterman MD- as though he was an expert. Besides, the Felder v. Casey precedent overcomes the implementation of a narrow local law when it unfairly deprives rights otherwise guaranteed under the United States Constitution. (1st, 7th, 14th Amendments)

Jurisdiction: In all cases, a DENIAL for Rehearing by the 3rd Circuit Appellate places the case in the U.S. Supreme Court for appeal. A. 24 (Panel:Rendell,Fuentes,Garth) Opinions Below: DC A. 1-18; 3rd Circuit A19-A.27

Constitutional Analysis: [Medical Malpractice Case]
"The Constitution of the Republic should make provision for medical freedom as well as religious freedom. To restrict the art of healing to one class of men (people) & deny equal protection to others will constitute the Bastille of Medical Science. by DR.BENJAMIN RUSH MD [Physician and Signer of Declaration of Independence]
The first amendment grants the Petitioner the right to petition the federal government for grievances. The fifth amendment guarantees the right to life and liberty under due process of law.
The seventh amendment preserves the right of trial by jury where the value of controversy exceeds $20. The Rule 50 argument curtailed this right of the Petitioner arbitrarily and against the public interest. Even the lower courts found trialable issues on the medical negligence issues. Essentially, a murky law gave the trial court the discretion to curtail the trial based on judgmental factors rather than "reserving judgment" to get a clearer sense of the comparative discussion of the evidence. In addition, the lower courts mis-apprehended the nature of a MINE claim which is a disease process where Medical Improvement Is Not Expected. The claim in this case is for the 12-5-96 to 9-15-99 period of non-discovery, non-monitoring and non-treatment of ankylosing spondylitis OR the risk matrix by the EADDY 694 for evaluating a case at the closure of the Plaintiff's Case in Chief. The trial court gave little or no weight to huge bodies of testimony by Diplomate Deng as to range of motion (5 months preceeding Dr.Mancall's exam) & the UCONN Medical School discovery of ankylosing spondylitis by Dr.Waterman-Rheumatologist,Internist.

These trial examinations and the treatment regimen Trial Exam of Dr.Kellman-MD-Treating Internist were ignored or given no weight due to METZELFELT - an ill-defined law in implementation in a parochial local practice setting. FR VOL 63 #35 2-23-98 FR 8890 was violated by not having a COMPLIANCE OFFICER.

Testimony

Joseph S. Maresca (Plaintiff) A.28-A.32 at trial
[Establishes that the plaintiff demonstrated spinal problems to Dr.Mancall and his medical student]
Diplomate Deng-Acupuncturist A.33 to A.43 at trial
[Independently authenticates the plaintiff's statement]
Dr.Mancall MD-Defendant A. 44 to A.56
[Demonstrates forgetfulness and failure to document]
Dr.John R. Waterman MD-Rheumatologist-Video at trial
Trial Transcript A. 57 to A. 70
[Demonstrates discovery and treatment regimen 9/15/99]
Dr.Kellman MD-Internist - Video at trial A. 72 to A. 82
[Demonstrates receipt of letter from Dr.Waterman and extensive treatment regimen in the 9/15/99 post period]
Diplomate Felder, Neurologist and Psychiatrist A.84-143
[practices in the art of neurology as does Dr.Mancall and reviews Dr.Mancall's exam faults and connects to risk from 12-5-96 to 9/1999 -explains treatment for symptoms only- connects to professional literature citations- definitively opines that plaintiff had Ankylosing Spon. on 12-5-96 and all symptomatology thereof]

Dr.Lee MD, PhD-Current treating physician explains comparison x-rays and schober tests after 2000 to 09/1999 A. 144 to A. 160 approved excerpts read at trial by the Plaintiff-Pro-se, Mr. Goewert, Esq. for Dr.Mancall and Dorothy Duffy, Esq. for Thomas Jefferson Univ. Hosp. The fourteenth amendment says that no state shall enforce laws that abridge the rights of citizens. The lower courts abridged rights by removing the Petitioner's case from a jury due to a murky law METZELFELT. The trial courts applied the wrong law. The correct law is EADDY 694.

In applying METZELFELT, the lower courts gave too much deference to the incurability issues which aren't mentioned in the law. The lower courts dismissed the competent testimony of Diplomate Deng on range of motion issues a full 5 months preceding the 12-5-96 exam by Dr.Mancall-the defendant. Dr.Waterman attested to a considerable musculoskeletal problem, spinal inflammatory issues, treatment protocols, daily exercise protocols and the certain existence of ankylosing spondylitis on 9/99. The lower courts failed to consider critical range of motion evidence in the forms of spinal x-ray reports and a memo describing the inability to do a sit-up or run [Approved Exh. 49] brought to the 12-5-96 defendant's exam by the Petitioner. A. 124, A. 125
This case was transferred from the Court of Common Pleas to the DC-Eastern Pa. on "diversity". It belongs in the Court of Common Pleas by the 11th Amendment. A23 The 27th amendment provides for equal rights and it is supplemented by further provisions in the Americans for Disability Act of 1991 providing added protection for Americans having disabilities. Ankylosing Spon. as defined defined in Smith v. U.S. RR Board 95-60433 contradicts the causality requirements of METZELFELT.

Statement of the Case
Facts
In August/1991, the petitioner visited Dr.Mancall at the Hahnemann Hospital in Philadelphia. The patient complained of intense lumbosacral strain and chronic low-grade fevers diagnosed in 12/91 as Crohns disease. Dr.Mancall ordered a complete MRI of the spine which showed discogenic disease at L-4 L-5 levels. The discogenic disease was treated with intensive physical therapy until a successful remission.
On 12-5-96, the petitioner again consulted Dr.Mancall complaining of intense pulling upward of the facial mask. He demonstrated a protruding head when standing erect.

In addition, the petitioner brought a memo describing an inability to do a sit-up or run. [A.124-125] Dr.Mancall watched the petitioner's demonstrations of the head protruding from the wall while standing erect and indicated to the petitioner " No. No. Don't Touch the Spine". A.32 Instead, Dr.Mancall ordered a brain MRI which the patient completed and a diagnostic report was sent to Dr.Mancall indicating cerebellar atrophy. [A.118-19] Dr. Mancall left the medical record with the words "Plan MRI, If Okay,Fiorinal, return post-MRI. " A. 115, A. 116: [Trial Exam testimony A28-54; A57-82;A83-143] The petitioner was told to take a muscle relaxant with a local practitioner only. The plaintiff's expert witness, Dr.Felder MD testified that the patient had ankylosing spondylitis and symptomatology thereof on 12-5-96. Dr.Mancall operated an Outpatient Clinic with his medical student residents from the medical college of the Thomas Jefferson University Hospital, Inc. An undisclosed medical student took the patient's medical history during the 12-5-96 examination.
Parties Whose Judgment Sought: The 3rd Circuit Panel 04-3103 and the DC Trial Court 01-5355 A.[1-25]

Reasons for Granting the Writ of Certiorari:# 1-5
[Initially Raised in DC Reconsideration-Docket 87 on]
1. The decisions of the 3rd Circuit and the DC circuit for Eastern Pennsylvania departed from the classic definition of Ankylosing Spondylitis in the federal law :
SSA. DI 280 40.001 MINE 416.99c
Federally, Ankylosing Spondylitis is classified as Medical Improvement Not Indicated so that the treatment protocol focuses on maintenance and the prevention of further disease progression- not curability as interpreted by the lower court decisions. The Pennsylvania medical malpractice law is being interpreted in a way that is counter to the longstanding precedent federally.

The concept of causality is irrelevant because the disease is incurable. A doctor can deal with pain/suffering and disease progression only.

2. The decisions of the lower courts conflict with another circuit on the same issue. Case 95-60433 involving Smith v. U.S. Railroad Board, 5th Circuit U.S. Court of Appeals , Politz, (Chief) set forth the Ankylosing Spondylitis disease criteria, known causality and most outstanding manifestations.

> **"He was diagnosed as suffering from Ankylosing Spondylitis, a chronic progressive and debilitating disease which fuses the spine and causes rigidity of the cervical, thoracic and lumbar vertebrae."**

These manifestations were proven by the Trial exam of Diplomate Deng-Acupuncturist a full 5 months prior to the visit to Dr.Mancall on 12-5-96. A. 33-43 and Diplomate Felder MD-Expert A 99-A 103 relies on the statements in formulating his opinion. The defendant's expert places the Ankylosing Spon. in the 1995-1996 period. A.164 and A. 161-165

3. The 3rd Circuit Court of Appeals has decided an important question of federal law that should be settled by the Supreme Court. The lower courts are confusing causality of the disease process Ankylosing Spondylitis with causality of the pain and suffering loosely connected to the physician negligence in the Metzelfelt criteria. The lower courts are writing new medical malpractice law. Only an appeal to the United States Supreme Court can decide definitively the dividing line of causality when a murky law does not provide decisive criteria understandable to a reasonable person or even the lower courts themselves.

Felder v. Casey , 487 U.S. 131, 138 (1988)

It has been clearly established that this Court will protect an individual's federal rights from being limited by local practice. The rulings of the 3rd Circuit and lower DC Court are a direct attack on this long held principle and also a violation of the Supremacy Clause and the Due Process Clause of the United States Constitution. 2nd, this Court has ruled that a state may not create "unreasonable obstacles" of an individual's federal rights.

Brown v. Western Railway 338 U.S. 294, 301 (1949)

The 3rd Circuit has used a confusing local law to deny a right granted to the petitioner federally by the Constitution and SSA DI 280 40.001 MINE 416.99c [MINE=Medical Improvement Not Expected] . The local law of Pennsylvania requires a causal connection between the physician negligence and the pain/suffering or harm. In addition, the local law is segmented into 2 parts.

The obviousness part of the law requires no expert if the manifestations are so obvious as to be perceptible by a non-expert; such as, Diplomate Deng-Acupuncturist. A. 33-43 The unobviousness part , espoused in Metzelfelt requires a loosely knit causal connection between the harm (pain/ suffering) and the physician negligence. The law doesn't say when or how to distinguish between obviousness and unobviousness with a uniform rule structure. The absence of a rule structure to determine causality creates enough confusion ; such that, a trial judge can abuse discretion without having the factual basis to do so. In formulating an opinion, Diplomate Felder relied upon a pyramid of facts gleaned from the filed depositions of the defendant, Dr.Mancall, Dr. Waterman MD-Rheumatologist-Trial Examination and Video and Diplomate Deng's deposition and subsequent 5-4-04 trial appearance, testimony and admitted documents - Trial Exhibits 1-40.

The trial judge discarded all testimony except for the expert-Diplomate Felder MD-Neurologist. Even the Pennsylvania law does not bar parol evidence or the testimony of treating physicians specifically. Besides, EADDY 694 is the applicable law for the Petitioner's Case in Chief closure on 5-5-04. Both lower courts have applied the wrong law to the facts.

"Accordingly, if a plaintiff has proven that the physician's breach increased the risk of harm, then there is sufficient evidence to overcome a motion for judgment as a matter of law. The expert in cases of this nature has been permitted to testify under the relaxed degree of certainty enunciated in Sec. 323a of the Restatement (Second) of Torts, that the defendant's failure to exercise reasonable care in the diagnosis and treatment was a substantial factor that increased the risk of harm. "

Eaddy 694 A 2d at 642 citing Billman 761 A 2nd at 1212-1213. [5-7-04 decision of the Honorable Judge Davis]

4. The lower courts stated the Metzelfelt rule of law improperly and they gave no credence to the obviousness criteria under Brophy:

Brophy v. Brizuela, 358 Pa. Super 400, 405, 517 A. 2nd 1293, 1296, '86

Clearly, the lower courts gave too much credence to the incurability of ankylosing spondylitis which dismisses the petitioner's pain and suffering unjustly for the period 12-5-96 to 9-9-1999 -the discovery of the Ankylosing Spondylitis at the UCONN Medical School facility. At the least, the DC court should have "reserved judgment" until the conclusion of the Defendants' Cases in Chief.

5. The previous Administration issued definitive guidance for strengthening the control structure of Teaching Hospitals, teaching physicians and residents in :FR Vol 63 #35 MONDAY 2-23-1998 P. 8990 The Office of Inspector General (OIG) required teaching facilities to engage a Compliance Officer to deal with areas of patient exposure and compliance reviews. The Petitioner tried to secure the testimony of the Compliance Officer on 11-12-02 by issuing a Motion to Compel the Thomas Jefferson University Hospital to provide answers on the existence of a Compliance Officer. If a Compliance Officer had been in place, the Petitioner's pain and suffering might have been halved because a quality control audit could have uncovered Dr.Mancall's non-monitoring of the case. The Court denied the motion on 11-20-02. Dkt. 26,30 The non-existence of a Compliance Officer could be a significant breach of the federal law; such that, the institution so far departed from accepted practice as to invoke the Supreme Court review.

The trial court requested that the parties limit their presentations to under 3 weeks. Accordingly, the parties accelerated the trial process by agreeing to call plaintiff witnesses first and deposing the defendant witnesses followed by the plaintiff cross examination. This prior agreement had the defendant and defendant experts being cross-examined in the Defense Case in Chief with no examination in the Plaintiff's Case in Chief. Although the Court sought to save time in limiting the trial to 3 weeks, the Court did not disclose how this would impact the Rule 50 invocation. In addition, at various junctures, the plaintiff complained that the defendant exhibits were being entered into evidence while the court did not prepare evidence forms for the plaintiff exhibits entered into evidence. A.16; A. 166 to A. 170

At the appellate level, the Court had no way of knowing which evidence was entered by the Plaintiff's Case in Chief because the DC court simply did not record the entry of the evidence. The combination of DC court errors, ambiguity of the Pa. law and judicial application of the Pa. law deprive the Petitioner of his 1st, 7th, 11th, 14th & 21st Amendment rights and guarantees under the Americans for Disability '91. The disability protections may apply to a pro-se as a defacto Officer of the Court .

6. Expert Testimony and Analysis:

During his 1-16-04 video trial deposition Diplomate Felder MD said: A 83 to A 143

Q. All right. Based upon the letter given to Dr. Mancall in the 12/96 exam describing the inability to do a sit-up or run, are those still very important things that have been brought to Dr.Mancall's attention that are pertinent to a diagnosis of ankylosing spondylitis.

A. Well , they would be pertinent. A.96; A. 114-116, A. 124-125; ALSO 3rd Circuit APP. A 133 p. 116 ln. 8 on and p. 115 ln. 3-15

Trial Exhibit 49 is a memo brought by the appellant to Dr.Mancall on 12-5-96 which he has admitted to reading. The memo mentions specifically the inability to do a sit-up or to run. A. 124 Admitted by the Trial Court

Dr. Mancall's 7-24-02 depo. A. 313 p. 46-7 & Diplomate Felder A.112 pp. 32 ln. 11- 3rd Circuit APP.

Q. Then there was another document which I brought to the Outpatient Neurology Clinic. I had given this initially to the medical student and I believe it is in the folder. At the bottom in the last- the next to the last paragraph I have in yellow. There appears to be some permanent restriction in the ability to do a sit-up or to run at maximum speed. That's mentioned in this along with other items. Did you read this memo at all?

A. Yes. (by Dr. Mancall)

Analysis:
Dr. Mancall knew the plaintiff had a restricted spinal ability to do a sit-up . He also knew that the musculoskeletal system was not working because the plaintiff could not run. He knew of discogenic disease by a '91 exam. [A 18-20 the 3rd Circuit APP.)
Dr. Mancall ordered a complete MRI of the spine during an 8/1991 full examination. A 126 to A 128
A reasonable person would conclude that upon leaving the exam with no spinal treatment protocol- this would be a harm causally connected to Dr. Mancall's exam or failure to investigate the spine in any depth. This aspect is cemented further by Diplomate Deng's appearance at trial A.33-43 Supplemental APP on Appellate Docket 56 & Dipl. Felder's Letter Trial Exh 142-5 & A 83-143

Diplomate Felder affirmed his expert letter of 11-22-02 in its entirety at the end of his trial examination.
A. I would say I still hold those conclusions. A.113 p.115

Diplomate Deng followed up with an Amicus Curiae brief setting forth the range of motion items in considerable detail. In the original ruling of 5-7-04, the Honorable Davis believed that Dr. Mancall had in his possession information as to the tension headache only. The Court erred in not considering the above testimony. A124-5
Dr.Mancall's testimony is laden with plausibly deniable statements designed to avoid paying the claim. A44-A54

In fact the plaintiff demonstrated the spinal limitations to Dr. Mancall during the 12-5-96 encounter and Dr.Mancall declared "No. No. Don't touch the spine.!" [A. 28-32] Dr. Mancall's failure to treat the spinal condition present was a substantial factor in bringing about the harm which was that the plaintiff continued to walk around/ambulate for 3 years until the correct diagnosis was made and treatment provided.

The plaintiff continued to walk, travel along subway platforms, drive and even engage in strenuous physical activity without knowing of the considerable implications to the musculoskeletal system due to the disease process Ankylosing Spondylitis. The aspects comport with the relaxed degree of certainty Section 323a enunciated by the Hon. Davis in his 5-7-04 opinion. Dipl. Felder concluded that the plaintiff had Ankylosing Spondylitis & symptomatology as of the 12-5-96 appointment. A 106 p.53, 54 and A 107- 114.

Dr. Waterman's testimony reinforces Dipl.Felder's belief of the disease existence on the date of Dr.Mancall's exam 12-5-96. A57-A71 and A 106, 107

New evidence resulting from a 5-31-05 pelvic area x-ray shows a total destruction of the sacroiliac joints: Source: Hudson Valley Radiology 5-31-05 [3rd Cir.Dkt. #47]

Dr. Waterman MD-Rheumatologist originally considered testifying as a Plaintiff Expert; however, he was barred from doing so by the Veteran's Admin. Hospital counsel. On A. 195, 196 the appellant lists 33 harms caused by Dr. Mancall's breach of duty in the Reconsideration memorandum A. 157 to A. 200 [3rd Circuit APP.]

The damages which flow from the harms are on A. 197. This Reconsideration Memo resulted in another 8/30/04 Order denying the case as per the Appellate Court filing in late July. The order is issued WITHOUT PREJUDICE. A. 0001

7. There is a massive forensic evidence attested to by Diplomate Dr. Felder MD regarding cerebellar atrophy, no analysis of the path of the tension headache, Diplomate Felder's assessment of Diplomate Deng's testimony, the blood sedimentary rate, gross Iritis/blindness in the eye, chronic inflammation and increased calcium formation noted with syndesmophyte formation and sacrum and ilium fused and the fact that the patient is not doing daily exercises to prevent further fusion of the joints due to inactivity. A. 99 to A. 114

Damages which flow from the harms can be reasonably inferred by a jury; A. 197 namely; (taken from Chart 4 of the Reconsideration Memo in the lower court Docket 87 DC 5-21-04 of the 3rd Circuit APP.)

- The patient isn't treating for an inflammation A. 160

- a huge amount of symptomatology is happening A. 120

p. 63 ln.12 onward A. 118 pp. 54 (Ref. are 3rd Cir.APP)

Q. Okay. Back on the record, utilizing Civil Rule 803.18 , which allows the discussion of scientific journal, medical journal type information, given this article Mortality Among Patients with Ankylosing Spondylitis Not Given X-ray Therapy.

This article mentions that these results of 836 patients with Ankylosing Spondylitis investigated indicate , at least in men, ankylosing spondylitis has life-threatening consequences related to many organ systems , consistent with systemic vascular degeneration as one long term consequence of the disease. In addition, mortality risk relative to the general male population was fourfold for all gastrointestinal disease, nearly twofold for accidents, suicide and cerebrovascular disease and 40% in excess for other circulatory diseases." A. 111 p.65-112

A. 134 (article summary)

This is a very critical part of the case because Dr. Mancall noted the Crohns Disease on the face of the Thomas Jefferson University Hospital encounter form . A. 115 (mid-pg. Crohns Disease- diagnosed '91"

Dr. Mancall's only test, an MRI of the Brain showed CEREBELLAR ATROPHY. A. 10 (Report of Dr. David Gerstman MD to Dr. Mancall 2-5-1997 A. 118, 119

" IMPRESSION: 1. CEREBELLAR ATROPHY A119

2. OTHERWISE NEGATIVE MRI SCAN OF THE BRAIN PRE AND POST CONTRAST...

Q. Okay. Dr. Felder, would you agree with the risks that are enunciated in this abstract of the New England Journal of Medicine? A. 134 (i.e. cerebral, suicide etc.)
A. In my opinion, yes.
Q. Okay. And would you agree that the plaintiff had those types of risks during the period 12-5-96 (Dr. Mancall's exam) through 9-5-1999, the date of discovery of ankylosing spondylitis?
A. It would be my opinion yes. A. 111-12 Ref. EADDY
This testimony falls within the relaxed standard of 323a of the Restatement of Torts enunciated in The Honorable Judge Davis's 5-7-04 Order by the Court.
The whole point of the article is what happens WITHOUT TREATMENT of the disease. The risks are: A. 111, A 134

8. Both the Crohns Disease and Cerebellar Atrophy are classic ankylosing spondylitis risks cited in the New England Journal of Medicine
Most importantly, the expert witness testified that he saw no indication that Dr. Mancall analyzed whether or not the cerebellar atrophy was problematic. A. 90, Dr.Mancall failed to analyze the GAIT of the patient by Diplomate Felder's testimony. Omission of the gait review is a classic part of a neurologic exam. A. 91

9. Damages which flow from harms continue on A197
[A 197-199, A118-121; A 301-25, A311 , A109 are the 3rd Cir. APP]
All references in Item 9 are in the 3rd Circuit-APP.
-the patient is wasting valuable money and time on ineffective medications
- a correct diagnosis and treatment would have given the patient an opportunity to prepare for predictable complications of the disease
- the patient is presenting lowered income on Trial Exh. 292-294

Damages which flow from the harms can be reasonably inferred by a jury; A. 197 namely; (taken from Chart 4 of the Reconsideration Memo in the lower court Docket 87 DC 5-21-04)

- The patient is not treating for a dangerous inflammation A. 160 (reproduced in 3rd Circuit APP.)

- a huge amount of symptomatology is happening A. 120 p. 63 ln.12 onward A. 118 pp. 54 ln. 5-21 A121 p. 65 ln.5 thru p.66 (reproduced in 3rd Circuit APP)

Trial Exh 292-296

- the patient cannot plan ahead without a diagnosis and has a 3 yr. career disruption

- patient is suffering random body fluids gyrations-blood sed rate A. 119 p.57-60 (reproduced in 3rd Cir. APP)

Most importantly, the Court should focus on the TJUH encounter form itself.

At the very bottom of the form, Dr. Mancall wrote "Plan MRI, If OK. Fiorinal". A. 115, A, 116 (Quotation)

That's how Dr. Mancall left the encounter form despite a finding of Cerebellar Atrophy and 3 successive memos to him which he read and did not act upon.

A. 301-325-3rd Cir.APP

Leaving an encounter form with no followup is reasonably a considerable basis for a formal admonishment of Dr. Mancall by the Pa. Medical Board.

The only things Dr. Mancall considered in the case are described in his deposition (cited by Diplomate Felder MD): A. 311 pp. 37, 38 (3rd Cir. APP.)

Despite the considerable cross-examination of Mr. Goewert, Esquire, the translation of Dr. Mancall's handwriting by Dr. Mancall himself constitutes the only verifiable things he considered on 12-5-96. [A.50]

A. All right. I wrote OE, which stands for on examination, obese, blood pressure 140/80, mentation check, which means normal, language check, which means normal. Cranial nerves all normal. Fundi check, means normal. Motor strength, bulk , tone, check, which means normal (note obesity). Deep tendon reflexes are two plus, equal Plantars, which is what PI stands for, plantars are downgoing, cerebellar function-normal, sensation normal. Diagnosis chronic tension headache. Rule out intraventricular tumor. Plan MRI. If okay, Fiorinal, return post-MRI. And then that's my signature scrawled out there. by Dr. Mancall A. 50 (Supreme Court APP) There is nothing on Dr. Mancall's encounter form about a postural component. In fact, the evaluation of posture was a key component of Dr. Waterman MD's examination. In addition, this is a BONE disease not an overweight disease.

" I had the opportunity of seeing Mr. Joseph Maresca at the University of Connecticut Division of Rheumatology on 9-8-99. As you are aware, Mr. Maresca is a gentleman with a great deal of musculoskeletal complaints.

In addition, he has a history of inflammatory bowel disease. "

Source: September 15, 1999 memo to Dr. Kellman MD by Dr. Waterman MD A. 67-9 Trial Exhibit 94

10. There is a massive amount of forensic evidence attested to by Diplomate Dr. Felder MD regarding cerebellar atrophy, no analysis of the path of the tension headache, Diplomate Felder's assessment of Diplomate Deng's testimony, the blood sedimentary rate, gross Iritis/blindness in the eye, chronic inflammation and increased calcium formation noted with syndesmophyte formation and sacrum and ilium fused and the fact that the patient is not doing daily exercises to prevent further fusion of the joints due to inactivity. A99-A114

Q. Okay. Dr. Felder, would you agree with the risks that are enunciated in this abstract of the New England Journal of Medicine? A111,A112, A134(ABSTRACT)
A. In my opinion, yes.
Q. Okay. And would you agree that the plaintiff had those types of risks during the period 12-5-96 (Dr. Mancall's exam) through 9-5-1999, the date of discovery of ankylosing spondylitis?
A. It would be my opinion yes.
This testimony falls within the relaxed standard of 323a of the Restatement of Torts enunciated in The Honorable Judge Davis's 5-7-04 Order by the Court.
The whole point of the article is what happens WITHOUT TREATMENT of the disease. A. 134 (ABSTRACT)

11. In fact, the evaluation of posture was a key component of Dr. Waterman MD's examination. In addition, this is a BONE disease not an overweight disease.
" I had the opportunity of seeing Mr. Joseph Maresca at the University of Connecticut Division of Rheumatology on 9-8-99. As you are aware, Mr. Maresca is a gentleman with a great deal of musculoskeletal complaints.

Dr.Bernard Alpers MD-Prof. of Neurology-Jefferson Medical College wrote a book entitled "Clinical Neurology", The Davis Co. 1950 in which he stated:
" The diagnosis (of Ankylosing Spondylitis) is made without difficulty, the stiff spine & back pain being quite distinctive in the early stages and root pains later.
Rule 50 Argument: DC Docket 85

12. Diplomate Felder MD recognizes the musculoskeletal problems as per the deposition of Diplomate Deng-Acupuncturist further memorialized in the Amicus Curiae brief to the Appellate Court and at trial .A33-43

A. I reviewed the records, the deposition of Dr. Elliot Mancall, deposition of Diplomate Deng and the deposition of Dr. John R Waterman MD, which you can see right here. These are--this is what I reviewed. A. 87
Diplomate Felder MD integrated the tension headaches with the Ankylosing Spondylitis in his Trial Testimony. [A. 112 pp. 84]
A. It's my opinion that headaches can be a secondary symptom of ankylosing spondylitis and that the neck is connected to the head, and if a patient has a great deal of cervical neck problems, it can cause tension headaches.
13. Diplomate Felder MD is presented with the 7-28-99 exam of Diplomate Abel MD.
A. Oh, feels like, " iron hand on scalp pulls upward for more than three years duration. A108-9 pp. 59, 60, Trial Exhibit 72, 73 of Diplomate Abel MD A131-2
Q. Okay, Diplomate Felder, is that notation consistent , in your medical opinion, with the existence of Ankylosing Spondylitis? A. Because it's showing limitation of movement and greater than three years duration.
Q. Okay, if you will go down further on the form, there is a notation see rheumatologist to evaluate for autoimmune disease, including blood work-ups.
Would you agree with that assessment by Dr.Carter Abel MD?
A. Yes, I think that's good. A 108 pp. 59, A.109
Q. Why is it a reasonable assessment?
A. Because blood work-ups would help give further information on why you're--you are having symptomatology, such as is stated in Harrison's Textbook of Medicine, looking at HLA-B27 , for example.
[HLA-B27 is a genetic known causality factor which defeats the defendants' claim that the expert witness did not address causality.]

Q. Okay. And also attached to that is the blood work showing the SED rate, the blood sedimentary rate?
A. Yeah
Q. Now, is that a normal SED rate that is being reported.
A. No, it's elevated. The reference range is 30. You had 38.
Q. And is that indicative of--of a more profound problem in the body system?
A. It would be indicative of a problem, yes.
14. Analysis: A.115, A.116
Trial Exhibit 43 is the Thomas Jefferson University encounter form. At the mid-page, the medical student wrote "pulling in stomach c belt lessons pulling of facial muscles which relieves pain". [12-5-96 encounter form]

The significance is that the same "pulling of facial muscles" described in the Thomas Jefferson University encounter form Exh. 43 is still there 3 years later by Diplomate Abel's encounter form except that the pulling is worse. The fact that the pulling is worse flows from Dr.Mancall's non-diagnosis.
A. Oh, feels like iron hand on scalp pulls upward for more than three years duration. A. 108 pp. 59, 60 Trial Exh. 72, 73 of Diplomate Abel A. 132, A. 135

This is a critical aspect because the same pulling of the facial mask is described in both the Thomas Jefferson University encounter form of 12-5-96 and the encounter form of Diplomate Abel MD on 7-28-99.

A reasonable person could conclude that the condition is still there and getting worse due to non-treatment. This would be a classic risk which comports with Sec. 323a of the Restatement of (Second) Torts.
15. Diplomate Felder MD confirmed the relationship between the tension headaches and the Ankylosing Spondylitis in the above.

A. It's my opinion that headaches can be a secondary symptom of ankylosing spondylitis and that the neck is connected to the head, and if a patient has a great deal of cervical neck problems, it can cause headaches. A. 112 pp. 84

From this testimony, a reasonable person could conclude that the problem is still there and getting worse due to non-treatment. The 12-5-96 encounter form of the Thomas Jefferson University Hospital mentions a pulling of the facial muscles. The 7-28-99 encounter form of Diplomate Abel MD mentions "an iron hand on scalp pulls upward for more than 3 years duration" .

The harm which reasonably flows from Dr. Mancall's exam is that the pulling is getting worse without treatment.[Sec. 323a of the Restatement of Torts]

Mr. Goewert, Esq. lead the expert witness, Diplomate Felder MD into another important omission of Dr. Mancall MD.

Q. Do you agree that chronic tension headaches was an appropriate diagnosis.
A. It can be a diagnosis, yes. It's a diagnosis of one of Mr.Maresca's symptoms. A. 113

[A. 126 pp. 85 ln. 16-19 and related reference A. 118 pp. 54 ln. 5-21 from the 3rd Circuit APPENDIX]

Analysis: The witness Diplomate Felder MD recognizes that the other two symptoms are the inability to run or to do a sit-up-up. These two symptoms were not addressed by Dr. Mancall despite the fact that the plaintiff brought a memo to the 12-5-96 visit describing the symptoms. A115, 116 and Trial Exh 49 and A. 124-125

Q. Okay. Dr. Felder, I'm giving you Exh 49, which is a memo prepared by myself and taken to the 12-5-96 encounter with Dr.Mancall to which he has admitted receiving and reading in his deposition. Okay. This letter mentions the permanent restriction in the ability to do sit-ups or to run at maximum speed. A. 96 pg. 32 ln. 11- A.97
A. That is correct, that's what it says.
Q. Diplomate Felder, in your opinion given that type of complaint, what would you do?
A. In my opinion, I would follow up with a patient until there was a specific diagnosis of their condition and/or they were having some improvement in their condition.
Q. Specifically, is there a diagnostic test that you would take to evaluate that complaint?
A. Well , certainly X-rays of the back. Again, one could consider MRI of the sacroiliac region, as per Harrison's Principles of Internal Medicine.
Q. Do you see any evidence on the face of the Thomas Jefferson University encounter form that indicates that Dr.Mancall considered any of those things?
A. I don't see such a thing
Q. And also in-- if you would repeat the diagnostic that you believe should have been taken?
A. The diagnostic test?
Q Yes, that's correct.
A. An MRI of the sacroiliac area, X-rays of the lumbosacral area, blood tests for HLA-B27 could have been possibly taken. (HLA-B27 refers to gene causality)
Q. And , Diplomate Felder, in taking those specific tests, do you believe that any one of those would have led to the discovery of ankylosing spondylitis? A. 97 ln. 20
A. It's my opinion that, yes, that would have given a strong indication.
Q. And could you attach the likelihood that it would have given a strong indication of ankylosing spondylitis?
A. In my opinion, within a reasonable degree of medical certainty, it would have given that in my opinion.

Q. Okay, also in your medical opinion, did Dr.Mancall ever analyze the path of the tension headache or the spinal root distribution?
A. I don't recall that being done. A. 97

16. Analysis:
Clearly, Dr. Mancall formed a working hypothesis of the tension headaches only. He omitted a working hypothesis of the inability to do a sit-up or to run. The appropriate tests to handle this portion of the complaint will have been the back x-rays and MRI of the sacroiliac area to discover the Ankylosing Spondylitis.

The expert is citing the fact that followup is necessary UNTIL IMPROVEMENT. In addition, the expert states that the ankylosing spondylitis would have been discovered with the back x-ray testing which provides a different outcome for the patient as opposed to waiting 3 years for a diagnosis and treatment regimen. A67-69
Dr. Waterman MD finally took the back x-ray 3 years later to discover the ankylosing spondylitis which was there 3 years earlier. Dr.Waterman MD prescribed an anti-inflammatory treatment regimen to reduce inflammation .

A reasonable person would infer that the the non-treatment of the Ankylosing Spondylitis which continued through discovery on 9-15-99 or thereabouts was very substantially within the control of Dr.Mancall such that the patient's risk of harm and actual harm increased.

17. The expert witness confirmed the diagnosis of Ankylosing Spondylitis from a fair reading of Dr. Waterman's testimony; such that, the disease was in place on the 12-5-96 date of Dr. Mancall's examination.

Q. And in reading the deposition of John R Waterman, is it your medical opinion that that deposition reinforces your belief that the existence of ankylosing spondylitis was in place of 12-5-96? Does that reinforce your suspicion that it was in place. A.106 pp. 53
A. It's my opinion that that would be correct.
Q. Okay. Meaning that--if you would elucidate on that?
A. That at the encounter, the original encounter that you had--SOMEONE TOOK MY LETTER--with--let me pull it out here. That on your 12-5-96 visit, you did have, it would be my opinion at that time, point in time, ankylosing spondylitis and symptomatology thereof.
[Note to Court: Diplomate Felder is referring to his 11-22-02 letter-Trial Exh 142-5 A. 135- A.143
Q. Okay. If you would go on pp. 24 of Dr. Waterman's deposition A. 106 pp. 54 to A. 107 (3rd Circuit APP)
A. Yeah
Q. He is talking about the importance of daily exercises?
A. Yes.
Q. Okay. Is it your-would you concur that his conclusion that the patient was not doing daily exercises at that point, would you concur that that was an important element of the patient's treatment?
A. I would concur with what Dr.Waterman is saying here.
Q. Maybe if you could read what he is saying?
A. Starting Line 15 pp. 24 A. 287
Q. Yes.
A. Question, in your examination of the patient, was it obvious to you that the patient was or did you elicit from the patient whether or not he was doing daily exercises, as opposed to periodic exercises?
Answer, I don't think that is noted. Question, was it evident that the patient was doing daily exercise?
A. I should say not. [A reasonable person could construe this as a harm-Note]
Q. Okay, I wanted to draw your attention to another item on pp. 26 line 18 A. 289 A. Yes

Q-- where he's mentioned about turning the head. If you could read ln 18-25
A. --when you examined the patient, did you turn the head from left to right?
Answer, yes. Did you find a normal range of motion?
Answer, no. What did you find?
Answer, decreased cervical range of motion in all directions, both passive and active.
Q. Okay. Diplomate Felder, could you define what decreased cervical range of motion would mean?
A. That would be decreased range of motion in all directions, is what he's saying here, of the neck, of moving your head back and forth, up and down, et cetera.
Q. And, Diplomate Felder, did you ever notice the patient moving his head to the left or to the right personally? Did you ever see the patient's head move left or right?
A. Meaning yourself..
Q. Yes
A. --since I've seen you? No, I haven't seen you do that.
Q. Okay, Do you believe you could rely upon Dr. Waterman's exam?
A. I believe so.
18. Analysis (A. 98- A 103)
Diplomate Felder MD confirmed the diagnosis of Ankylosing Spondylitis by two independent fact witnesses; namely, Diplomate Charles Deng and Dr. John R Waterman MD. Diplomate Felder MD placed this diagnosis squarely within the 12-5-96 examination of Dr. Mancall MD. In addition, the decreased cervical range of motion observations of Dr. Waterman MD mirror Diplomate Deng's findings cited for the 7/96 time period-a full 5 months preceding Dr. Mancall's examination. The harm, according to Dr. Waterman, is that the patient is not doing daily exercises AND DIPLOMATE FELDER AGREES.

The fact that the patient is not doing daily exercises is a harm flowing from Dr.Mancall's non-diagnosis because the patient is not getting the benefit of pain alleviation and an enforced program of moving the joints so that they do not fuse or inflame further from the processes of ossification and calcification by a reasonable person's interpretation or logical inference. Also , the diagnosis, treatment regimen and analysis in Dr. Waterman's deposition may be admissible by the Court because Diplomate Dr. Felder MD stated a general reliance upon Dr.Waterman's exam in its entirety. A. 264 to 300 (deposition of Dr. Waterman MD in 3rd Circuit APP.)
Q. There's a suggestion of multilateral facet fusion. What is that?
A. That's different levels where the facets of the vertebrae are fusing, are coming together very tightly. A. 99
19. Once the expert witness, Diplomate Felder MD, has made an assessment of the ankylosing spondylitis in the 12-5-96 examination time frame of Dr. Mancall MD, the Court cannot substitute its assessment for Diplomate Felder's judgment.
20. A reasonable person could conclude that the treatment regimen for ankylosing spondylitis would attach itself to the diagnosis and untreated symptomatology. How could a reasonable person conclude that the patient was treating for the disease process without a correct diagnosis in place? Until 9/1999, the patient had no basis to know of the disease process ankylosing spondylitis or the alternative treatments available because Dr. Mancall did not make a diagnosis for at least 2/3 of the complaint dealing with the inability to do a sit-up or to run .

Related ref. [A 118 pp. 54 ln. 5-21 ;A. 119 p. 60 ln.19-25
A. 114 p.37 la.9 to p. 39: A.120 p.61 L1-8;
A. 120 p. 63 ln. 12-25 - 3rd Circuit APP.

A. Well, you have a cervical spine with oblique views, with the impression of ossification of the anterior longitudinal ligament, findings consistent with multi-level facet fusion. A differential diagnosis for these findings would include ankylosing spondylitis, as well as other seronegative spondylarthropathies. There's also a lumbosacral spine showing ossification of the anterior longitudinal ligament, mild disk space narrowing, overgrowth in calcifications, fusion of the sacroiliac joints. What's--that's basically it. A. 98

Q. Okay. If you could review for us what is an ossification?

A. It's a bony-a formation--increased bone formation, like from the word ossify.

Q. And what are the implications of that for the patient?

A. Could be chronic inflammation, increased calcium formation.

Q. Diplomate Felder, would you kindly summarize the types of difficulties the patient complained of and that, in your neurologic opinion, you felt were indicative of ankylosing spondylitis? A. 110 p. 63

A. Well, the patient, yourself, had numerous symptoms, rigidity of the head, neck, spine, loss of range of motion, difficulty, for example, using a computer, extensive talking has become difficult for you. Oh, here I did say you developed Iritis on 5-20-1997, yeah. I did apparently note that somewhere. That you've had Crohns disease, it's been exacerbated. You've had tinnitus, which is sounds--a sound of noise in the ears. Difficulty going over in bed, moving around in bed, I should say. Tying your shoes, putting on socks, trembling of hands, feet, occasional feelings you've stated that your body seems to freeze up.

[Clearly, Diplomate Felder MD is quoting from his 11-22-02 expert letter A.135-43 by a fair reading of A. 110-11; Iritis symptoms on A 110 p. 63 ln. 8-17]

In fact the risks were not only there, they were exacerbated!
" I did apparently note that somewhere. That you've had Crohns disease, it's been exacerbated. " A. 110; A135-42
The expert squarely places the ankylosing spondylitis in the 12-5-96 time period and he states that the patient presented with the disease at Dr.Mancall's exam. Therefore, all of the ankylosing spondylitis symptomatology may be inferred by a reasonable person as a risk from Dr. Mancall's exam date on. (12-5-96 to 9/1999)

21. An example of the non-monitoring is as follows:
Q. Now with a finding of cerebellar atrophy, do you see on the TJUH encounter form any evidence that Dr.Mancall came to a conclusion on whether or not the cerebellar atrophy was problematic? A 90-91
A. I can't recall that he did come to that conclusion that it's problematic.
Q. So would it be safe to say that you really--you have no way of knowing what conclusion or what documented conclusion Dr.Mancall came to from looking at the Thomas Jefferson encounter form? A 91
A. That is correct.
Analysis
Clearly, Dr. Mancall MD did not monitor the case-even on the Brain MRI directed to him showing cerebellar atrophy. The bottom of the TJUH encounter form states clearly "Plan MRI, if OK, Fiorinal." Admitted Trial Exhibit 0008 and A. 115- 117

If Dr. Mancall did not make a correct diagnosis, take the correct test or monitor the case- how could a reasonable person believe that the patient has treated for Ankylosing Spondylitis without a diagnosis?

Q. Okay. And would you agree that the patient had those risks during the period 12-5-96 through 9-15-1999, the date of discovery of ankylosing spondylitis?
A. It would be my opinion yes. A. 112 top; A. 134 risks

22. The question is whether or not a reasonable person could conclude that Dr. Mancall failed to exercise reasonable care in the diagnosis and treatment such that this would have been a substantial factor increasing the risk of harm.
[Section 323a of the Restatement (Second) of Torts]

Q. On 12-5-96, did Dr.Mancall make a correct diagnosis?
A. No. It is my opinion, medical opinion, that the correct diagnosis would have been ankylosing spondylitis.
A. 88 pp. 13 ln. 12
Q. What causes you to have that opinion? A. 89
A. A number of problems. First of all, that there was an insidous onset of the condition as per Harrison's Principles of Internal Medicine, duration greater than three months, morning stiffness. There was some improvement with exercise or activity, from what I read in the record of testimony. And the fact that, of course, that the correct diagnosis was achieved by Dr.Waterman MD at a later date. A. 89 to A. 93
[The later date is 3 years later 9/99]
Analysis
A reasonable person could infer that there could be no treatment of ankylosing spondylitis without a firm diagnosis. The firm diagnosis was not made for another 3 years until the correct diagnosis by Dr. Waterman MD. The intervening years until diagnosis left the patient untreated for ankylosing spondylitis. Diplomate Deng's deposition reinforced Diplomate Felder's belief that the ankylosing spondylitis was in place on 12-5-96.

**[The appellant read several pages of Dipl. Deng's testimony into the record. [A. 99 to A. 103]
Diplomate Felder MD placed the Iritis within 6 months after Dr.Mancall's exam and explained that it was an Ankylosing Spondylitis marker. A. 110**

**Q. Diplomate Felder. In reviewing those depositions, what are your findings specifically, & if you could focus on Dr.Mancall's depositions. A . 88 ln. 18; A. 89
[There is a typo in the transcript. Diplomate Deng s/b Diplomate Felder. The correct proceeding is in the Video because the voice is captured as Diplomate Felder MD.]
A. My-after reviewing this, it was my conclusion that the patient's head movements were not examined, nor was the--there to my knowledge, reviewing these documents, in my medical opinion, an examination
of the spine. There was no recollection of the patient's position. There was deficiency of looking at neck posture. There was deficiency in not looking at neck posture. There was no evaluation of the pelvic area. There was no examination to my knowledge of rotation of the thigh. The patient, yourself Mr.Maresca, was given a diagnosis of chronic tension headaches at the time. I reviewed of course Dr.Mancall's testimony and this sheet here, which is the sheet that--from Thomas Jefferson University Hospital physical exam. It's somewhat difficult to read but you know you see motor, deep tendon reflexes.**

Analysis
The insidious onset places the events in the 12-5-96 time frame and the witness cites improvement with exercise which comports with Dr. Waterman's indication that daily exercise is required. Clearly, this insidious onset is untreated without a firm diagnosis, monitoring and treatment. The identified medical student wrote "Headaches @ 7 months duration" at the top of the TJUH encounter form A. 115, 116

On cross-examination, the expert witness, Dr.Felder MD explained that the treatment goal for ankylosing spondylitis is alleviating symptomatology only. A. 113 pg. 110
Q. Would you agree that there's no known medication which has clearly been shown to alter the natural history of the disease (ankylosing spondylitis) ?
A. That's correct.
Q. Okay. A. Its treatment of symptomatology.
Q. You treat symptomatology. A. Yeah.
[since disease is incurable only symptoms can be treated]
23. This is a multiply-dependent expert witness testimony of Diplomate Felder MD dependant upon the plethora of facts gleaned from the deponents Maresca, Mancall MD-defendant, Diplomate Deng-Acupuncturist at Trial 5-4-04 the Trial Exam of Dr.Waterman MD-Rheumatologist on 5-4-04 by Video, the Trial Exam of Dr.Kellman -Internist and treating Internist, Diplomate Felder MD-Neurologist and Expert Witness.Video and transcript The Trial Exhibit Vols 1,2 are on the DC Dock#75-Exhibits 1-300

Reliance by the Diplomate Felder MD on Dipl. Deng's exam is listed on A. 100 and Dr. Waterman's exam A106. In the Rule 50 argument, the plaintiff/appellant quoted from Clinical Neurology by Dr.Bernard Alpers MD-Neurologist - Professor of Neurology of the Jefferson Medical College 1950 Davis Company

" The diagnosis is made without difficulty, the stiff spine and back pain being quite distinctive in the early stages and the root pains later. Exam reveals a stiff, rigid "poker" spine usually in the thoracic & lumbar regions but often affecting the entire spine. The normal lumbar lordosis is lost. The head is thrust forward & the trunk held rigidly in walking. Kyphosis develops, but not in all cases. The spine muscles are held in spasm & become atrophic later in the disease. The disease is usually slowly progressive, though it may cease to progress at any stage. Bony ankylosis develops after 10 to 20 years and pains cease. DC docket 85

24. The plaintiff seeks RELIEF in the form of financial recovery under the MCARE of Pennsylvania allowing for $750T liability coverage consisting of pain and suffering and whatever additional relief a jury will provide for the non-discovery of ankylosing spondylitis and the period of distress from 12/96 to 9/15/99 the reasonable discovery date of the disease & the 2001-06 petitioner's litigation period which interfered with every aspect of life. Pain and suffering relief may be granted in the amount of $250,000 or more together with any other relief that a jury might grant by inferring damages of a permanent nature.

25. Final Disposition of the Case

"The first 10 years of the disease is particularly important with respect to ultimate outcome. " A.113 pg. 114 ln. 21

To accomplish a reasonable settlement of these claims, the Petitioner asks that the Supreme Court send the case back to the Appellate Court for further arguments or to the District Court of East. Pennsylvania for a new trial with possible instruction on the use of Eaddy's 694 at the Plaintiff's Conclusion of the Case in Chief or a clearer definition of what constitutes a reasonable interpretation of obviousness and unobviousness under the Pennsylvania law. The Supreme Court could send the case back to the Court of Common Pleas in Philadelphia where it was filed originally. The Thomas Jefferson University Hospital moved the case to the federal jurisdiction on the pretext of diversity; however, the State courts have the in depth knowledge of the law. The defendants moved the case to a federal jurisdiction because federal juries tend to be selected from all over Pennsylvania and ;resultingly, somewhat less money has been awarded to plaintiffs than a jury of peers in Philadelphia. At trial, the plaintiff will amend the video trial testimony and /or confront the defendants with a rigorous discussion of the Expert Letter of Diplomate Felder which contains many details on treatment and damage rationales.

In addition, the plaintiff will request that a new Trial Court provide a better audit trail to the evidence entered.

APPENDIX

BOOK I:

OPINIONS BELOW: A. 1 to A 27

A.1 8-30-04 order DENYING Motion for Reconsideration WITHOUT PREJUDICE by the DC Court

A.2.to A.14 5-10-04 Order granting Motion as a Matter of Law -Civil Rule 50 to Defendants

A.15 -A.16 Substantial Deviation from good juridical practices

A.17-A.18 Relevant portions of the DC Docket

A.19-23 Not Precedential 6-16-05 opinion of the 3rd Circuit Court of Appeals by Garth

A.24 Denial of Petition for Rehearing 12-19-05

A.25 3rd Circuit Court of Appeals Docket 1-21

SUBSTANTIAL DEVIATION JUSTIFYING THE SUPREME COURT REVIEW A. 15 , A.16, A.23

11th Amendment-suits in equity are tried in State Courts not federal courts. 1795.

APPENDIX

BOOK 2

A.135-A143	Dr.Felder MD-Neurologist expert letter sequences read in the trial exam and affirmed at the end of the trial exam.
A.83-A143	Trial Exam of Diplomate Felder MD-Neurologist and Psychiatrist
	The above multiply depends on the following testimonies:
A28-A32	Plaintiff testimony on range of motion issues and demonstrations to Dr.Mancall on 12-5-96.
A.33-A43	Authenticating trial exam and Amicus Curiae brief of Diplomate Deng-Acupuncturist which demonstrates range of motion issues 7/1996.
A44-A54	Dr.Mancall's plausibly deniable statements on all range of motion issues existing 12-5-96
A57-A71	Trial exam of Dr.Waterman MD-Rheumatologist at UCONN now working at Newington V.A. Hospital
A70-1	Spinal x-ray exams of Dr.Waterman 9-9-1999
A72-A89	Trial Exam of Dr.Kellman MD-Internist who treated the patient for significant back inflammations after Dr.Waterman's diagnosis
A144-60	Testimony of Dr.Lee MD,PhD read at trial confirming the disease process Ankylosing Spondylitis and the treatment modalities including comparison x-rays and Schober tests of spinal flexion from the dimples of Venus

UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF PENNSYLVANIA

Joseph S. Maresca, CIVIL ACTION
PLAINTIFF

v.

Elliot L Mancall MD and
Thomas Jefferson University Hospital
DEFENDANTS

ORDER

And now, this 30th day of August, 2004, upon consideration of the Motion for Extension of Time filed by Plaintiff on Aug. 5, 2004 (Doc. 95), it is hereby ordered that the Motion for Reconsideration is DENIED without prejudice. Because Petitioner filed a Notice of Appeal, the Court lacks jurisdiction to entertain this Motion for Extension of Time. Petitioner is directed to file said Motion and all subsequent motions with the Court of Appeals.

By The Court

Legrome D. Davis, Jr.

IN THE UNITED STATES DISTRICT COURT
FOR EASTERN DISTRICT OF PENNSYLVANIA
JOSEPH S. MARESCA CIVIL ACTION
Plaintiff
v.
ELLIOT L MANCALL, MD AND
THOMAS JEFFERSON UNIVERSITY
HOSPITAL
DEFENDANTS

ORDER

1. INTRODUCTION

Presently before the Court are the Motion for Judgment as a Matter of Law filed by THOMAS JEFFERSON UNIVERSITY HOSPITAL ("TJUH") on April 26,2004 (Doc. 79), the Opposition to the Motion for Judgment as a Matter of Law filed by Plaintiff -Joseph S. Maresca (Plaintiff) on May 3, 2004 (Doc. No. 83) , the Motion for Judgment as a Matter of Law filed by Defendant Elliot L Mancall MD (Dr. Mancall) on April 28, 2004 (Doc. 80) and the Opposition to the Motion for Judgment as a Matter of Law filed by Plaintiff on May 3, 2004 (Doc. 84)

II. FACTUAL AND PROCEDURAL HISTORY

Plaintiff, proceeding pro se, initiated this medical malpractice action in state court in September 2001 against Dr.Mancall and TJUH (together "Defendants"). After the action was removed to this Court by Defendants, Plaintiff filed a Complaint on February 14, 2002, generally alleging that he was examined by Dr. Mancall on or about December 5, 1996, that he was at that time suffering from particular symptoms which Dr.Mancall should have recognized as corresponding to a medical condition called Ankylosing Spondylitis; that Dr.Mancall failed to diagnose his condition; that he did not realize that he suffered from ankylosing spondylitis until over two years later, and that Dr.Mancall's failure to diagnose his condition resulted in his continued suffering from the condition and the further progression of the condition. [1] The Complaint can be fairly read to set forth three claims: (1) a medical malpractice claim against Dr. Mancall based on his alleged failure to diagnose Plaintiff's condition, (2) a claim against TJUH alleging vicarious liability for Dr.Mancall's actions based upon the theory of respondeat superior, and (3) a claim against TJUH based upon the doctrine of corporate negligence.

During discovery, the Plaintiff provided two pre-trial reports from a neurologist, Mitchell S. Felder MD, his only medical expert witness. On the basis of these reports, the Court denied summary judgment to both defendants on 6-20-2003.

Footnote :

1. Ankylosing Spondylitis is a chronic form of arthritis that affects the spine, causing pain, stiffness,swelling, and limited motion in the back, neck, and hips. WJ Koopman, ed. ARTHRITIS AND ALLIED CONDITIONS: A TEXTBOOK OF RHEUMATOLOGY, 14th edition, vol. 1, 1312-1323

(Doc. 047). 2 The parties attended a final pretrial conference on December 11, 2003 (Doc 52). At the second pretrial conference and hearing on May 3, 2004, the Court heard argument on the Defendants' motions filed pursuant to Rule 50 of the Federal Rules of Civil Procedure and concluded that, because trial had not yet commenced, the motions were untimely. At the close of Plaintiff's case, Defendants renewed the motions for judgment as a matter of law. The Court heard oral argument on 5- 5, 2004. Hrg.Tr.2

III. STANDARD OF REVIEW

A motion for judgment as a matter of law should be granted only if, "viewing the evidence in the light most favorable to the non-movant and giving it the advantage of every fair and reasonable inference, there is insufficient evidence from which a jury could reasonably find liability." Gagliardo v. Connaught Laboratories, Inc. 311 F.3d 565, 568, (3rd Cir. 2002) (quoting Fulz v Dunn 165 F.3d 215, 218 (3d Cir. 1998); see Hrg. Tr . at 11 (explaining the standard of review for judgment as a matter of law to Plaintiff.) "Although a scintilla of evidence is not enough to withstand a motion for judgment as a matter of law, the denial of a motion for judgment as a matter of law is proper unless the record "is critically deficient of that minimum quantum of evidence from which a jury might reasonably afford relief." Denneny v. Siegel, 407 F 2d 433, 439-40 (3rd Cir. 1969)(citations omitted). The court is not free to weigh the evidence or to pass on the credibility of witnesses or to substitute its judgment of the facts for that of a jury. Lightning Lube v. Witco Corp., 802 F. Supp. 1180, 1885 (D.N.J. 1992) aff'd by 4 F.3d 1153 (3d Cir. 1993).

Footnote :

2. At all stages of the litigation, the Court made every effort to insure that Plaintiff understood the difference between evidence submitted to withstand summary judgment and the burden of proof at trial. See eg.Hrg. Tr. at 9-10,14-15

A case may not be taken away from the jury merely because of speculation and conjecture is required" when facts are in dispute and fair-minded individuals may draw differing inferences." Lavender v. Kurn, 327 U.S. 645, 653 (1946)). The motion must be denied "if there is evidence reasonably tending to support the recovery by the plaintiff as to any of his theories of liability." Hofkin v. Provident Life and Accident Ins. Co., 81 F. 3rd 365, 369 (3rd Cir. 1996).

IV ANALYSIS

A. Plaintiff Cannot Establish a Prima Facie Case of Medical Malpractice Against Dr.Mancall

In order to establish a prima facie cause of action for medical malpractice, a plaintiff must demonstrate that " (1) the physician owed a duty to the patient; (2) the physician breached that duty (3) the breach of duty was the proximate cause of, or substantial factor in, bringing about the harm suffered by the patient, and (4) the damages suffered by the patient were the direct result of that harm. "Billman v. Saylor, 761 A 2d 1208, 1211-12 (Pa. Super. 2000) quoting Eaddy v. Hamaty, 694 A 2d 639, 642 (Pa. Super. 1997). Because "the complexities of the human body place questions as to the cause of pain or injury beyond the knowledge of the average layperson," a medical malpractice plaintiff generally must produce the opinion of a medical expert to demonstrate the elements of his cause of action.

Masgai v. Franklin , 787 A 2d 982, 985 (Pa. Super 2001) citing Miller v. Sacred Heart Hosp., 753 A 2d 829, 833 (Pa. Super. 2000) (Quoting Hamil v. Bashline, 481 Pa. 256 , 392 A 2d 1280, 1285 (1978). 3

1. Expert Testimony of Dr.Felder Insufficient to Establish Deviation from Medical Standard of Care

To support his medical malpractice case against Dr.Mancall, Plaintiff presented, via videotape trial testimony, the expert medical testimony of Mitchell S. Felder MD. In medical malpractice actions, the expert witness must testify, to a reasonable degree of medical certainty, that the acts of the physician deviated from good and acceptable medical standards, and that such deviation was the proximate cause of the harm suffered. Mitzelfelt v. Kamrin 526 Pa. 54, 62, 584 A 2d 888, 892 (Pa. 1990) citing Brannan v. Lakenau Hospital, 490 Pa. 588, 417 A 2d 196 (1980); Eaddy v. Hamaty, 694 A 2d 639, 642 (Pa. Super. 1997); Hrg. Tr at 22-23. An expert need not testify with absolute certainty or rule out all possible causes of a condition, nor must the expert testify in precisely the language used to enunciate the legal standard. Id.; In re Jones, 432 Pa. 44, 246 A 2d 356 (1968)(medical testimony need not conform to precise statutory definitions). Instead, the Court reviews the expert testimony in its entirety to assess whether it expresses the requisite degree of medical certainty.

Footnote 3:
The doctrine of res ipsa loquitor under which expert testimony is not required to establish a breach of duty "'where the matter under investigation is so simple, and the lack of skill so obvious, as to be within the range of the ordinary experience and comprehension of non-professional persons." is inapplicable to this case. Id at n. 11, 698 A 2d at 585 n. 11 (quoting Chandler v. Cook, 438 Pa. 447, 451 n 1265 A 2d 794, 796 n.1 ('70); see Toogood v. Rogal. 573 Pa 245 , 256-7, 824 A 2d 1140, 1146-47(E.D. Pa 2003); Hightower-Warren v. Silk, 548 Pa. 459, 463-4, 698 A 2d 52, 54-55(1997). The allegations made against both Dr. Mancall and TJUH are well beyond the knowledge of average lay people. Hrg. Tr. at 8-9

McCann v. Amy Joy Donut Shops, 325 Pa. Super 340, 343-44, 472 A 2d 1149, 1151 (1984) (en banc) In this case Dr.Felder testified only that, though Plaintiff complained only of headaches, Dr.Mancall failed to examine the patient's head movements or conduct examination of the spine, neck posture, pelvis, and thigh rotation. Test. Tr. at 12-14; Hrg. Tr. at 22. Dr.Felder offered his medical opinion that, on the basis of the symptoms presented by the Plaintiff, the appropriate diagnosis would have been ankylosing spondylitis. Id. On direct examination, Dr.Felder suggests numerous examinations that Dr.Mancall could have taken to yield such a diagnosis, Id. at 16-20. Finally, Dr.Felder testified that in his opinion, a doctor should respond to written correspondence from a patient and should followup with that patient. Id at 24-25, 53-54; Hrg. Tr at 24, 31

But Dr.Felder later retreated from that position during cross-examination, conceding that his opinion resulted from medical information not available to Dr.Mancall at the time of his diagnosis; the examination conducted by Dr.Mancall yielded an appropriate diagnosis of chronic tension headaches; nothing in Dr.Mancall's record of 12-5-96 or in subsequent letters from Plaintiff to Dr.Mancall indicated a history of complaint of progressive neck stiffness or pain by Plaintiff; Dr.Mancall's request for an MRI and prescription for medication were appropriate; some subsequent efforts by Dr.Mancall to followup were indicated by the record; and the information available to Dr.Mancall would not suggest the need for a back examination.

Id. at 85-86, 92, 96-7; Hrg. Tr. at 25. When reviewed in its entirety, the testimony fails to express the requisite degree of medical certainty as to a failure by Dr.Mancall to perform his examination within the requisite standard of care.

2.Expert Testimony of Dr.Felder Fails to Establish Causation

But, even if, when viewed in the light most favorable to the non-movant, this testimony could be viewed by a reasonable jury to indicate that Dr.Mancall deviated from some medical standard of appropriate care, the necessary showing of causation is totally absent. In addition to proving that the defendant breached a duty owed, the Plaintiff must also establish that the breach of said duty was the proximate cause of bringing about the harm suffered by the Plaintiff. Joyce v. Boulevard Physical Therapy & Rehabilitation Center, P.C. 694 A 2d 648, 657 (Pa.Super, 1997)
"An expert fails this standard of certainty if he testifies "that the alleged cause "possibly" or "could have" led the result, that "it could very probably account" for the result, or even that it was "very highly probable" that it caused the result.

Kravinsky v. Glover 263 Pa. Super. 8, 21, 396 A 2d. 1349, 1356 (1979) citations omitted; Hrg. Tr. at 25
At no point did Dr.Felder assert that Dr.Mancall could have prevented or cured Plaintiff's condition had he diagnosed it earlier. Rather, Dr.Felder acknowledged no cure, definitive treatment, or medication exists for ankylosing spondylitis that can alter the natural progression of the disease. Test. Tr. at 110; Hrg. Tr at 26-27.

During oral argument on the motions before the Court on 5-5-04, in response to the Court's request that Plaintiff point to any instance in the expert witness' testimony where causation had been remotely discussed. Plaintiff instead read from treatises, pointed to exhibits not in evidence, & conjectured about testimony he expected to elicit from defense witnesses. Hrg. at 37-47. Therefore, Plaintiff failed to establish that Dr.Mancall's allegedly negligent treatment was the proximate cause of his subsequent condition of ankylosing spondylitis and its related symptoms.

However, in medical malpractice actions involving incurable illnesses, because a causal connection between the care provided by a physician and the resulting injury can often not be established to such a reasonable degree of medical certainty, the Court requires only that the treating physician's negligence was a substantial factor in causing Plaintiff's injury. Joyce 694 A 2d at 657. [4] In such cases, we require only that the treating physician's negligence was a substantial factor in causing plaintiff's injury.

Footnote 4: In cases where irrespective of the quality of the medical treatment, a certain percentage of patients will suffer harm, the standard of proof regarding medical expert testimony is " an impossible standard." Mitzelfelt at 62. In such instances, the Plaintiff must show "to a reasonable degree of medical certainty that the physician's actions/ omissions increased the risk of harm" in order to proceed to the jury. Billman 761 A 2d at 1213 citing Montgomery v. S. Phil. Medical Group Inc. 441 Pa Super, 146, 656 A. 2d 1385 (1995)(Following testimony of a physician's act or omission that "increased the risk that the plaintiff would have either a shortened life expectancy or suffered harm," a jury may consider whether "the acts or omissions of the physician were a substantial factor in bringing about the harm."). The Court notes that in Penn. this relaxed standard has traditionnally been applied to cancer patients for whom early detection can be lifesaving. It hasn't generally been applied to to degenerative illnesses for which no cure or treatment meaningfully alters the disease progression.

ID Accordingly, if a plaintiff has proven that the physician's breach increased the risk of harm, then there is sufficient evidence to overcome a motion for judgment as a matter of law. Id see Montgomery v. South Philadelphia Medical Group, Inc. 441 Pa. Super. 146, 656 A 2d 1385 (1995) ; Clayton v. Sabeh, 406 Pa. Super 335, 594 A 2d 365 (1991) The expert in cases of this nature has been permitted to testify under the relaxed degree of certainty enunciated in Sec. 323(a) of the Restatement (Second) of Torts, that the defendant's failure to exercise reasonable care in the diagnosis and treatment was a substantial factor that increased the risk of harm. Eaddy 694 A 2d at 642 citing Billman, 761 A 2d at 1212-1213. In fact, Dr.Felder never articulated any difference that would have resulted in Plaintiff's ultimate prognosis had Dr.Mancall diagnosed him on December 5, 1996 or any injuries that resulted from Dr.Mancall's alleged mis-diagnosis. During oral argument, Plaintiff pointed only to Dr.Felder's tenuous conclusion that his Crohns disease had been exacerbated without any connection between that exacerbation and Dr.Mancall's diagnosis. Test Tr. at 63; Hrg. Tr. at 33 As a result Dr.Felder's critically deficient expert testimony, Plaintiff has failed to establish that the care Dr.Mancall provided was a factor in causing or increasing the risk of his illness such that a reasonable jury could find in his favor. Hrg. Tr. at 56-58

B. Plaintiff Cannot Establish a Prima Facie Case of Vicarious Liability Against Thomas Jefferson Univ. Hospital

Because Plaintiff fails to establish that Dr.Mancall caused his alleged injuries, any claim of vicarious liability against TJUH must likewise fail. The Pennsylvania Supreme Court has held that because "the corporate hospital of today has assumed the role of a comprehensive health center," it may be subject to theories under respondeat superior, ostensible agency, and/or corporate negligence. Thompson v. Nason Hospital, 527 Pa 330, 338-40, 591 A 2nd 703, 706-7 (1991)

In order to find liability on the part of the TJUH under a theory of respondeat superior, Plaintiff must establish that Dr.Mancall was an agent of the hospital and liable for the injuries claimed. Hannis v. Ashland State General Hospital 123 Pa. Cmwlth., 390, 397, 554 A 2d, 574, 578 (Pa Cmwlth 1989) citing Capan v.Divine Providence Hospital, 287 Pa. Superior Ct., 364, 430 A 2d 647 (1980). An agency relationship results from (1) the manifestation of consent of one person to another that (2) the other shall act on his behalf and subject to his control, and (3) consent by the other so to act: Id. at 414 citing Chalupiak v. Stahlman, 368 Pa. 83, 81 A 2d 577 (1951); Restatement (Second) Agency Par 1(1) (1958). Only an agreement for the creation of a fiduciary relationship with control by the beneficiary creates such an agency. Rosenberg v. Cohen, 370 Pa. 507, 88 A 2d 707 (1952). At oral argument, though Plaintiff points to the presence of the TJUH logo on the encounter form completed by Dr.Mancall that does not suffice to establish an agency relationship. Hrg. Tr. at 11-15, 18-21; Tr. 43

Not only is there no evidence of record that creates an agency relationship, plaintiff fails to establish his claim of negligence as a matter of law against Dr.Mancall. As such, the claim of vicarious liability against TJUH cannot succeed.

C. Plaintiff Fails to Establish a Corporate Liability Claim Against Thomas Jefferson University Hospital

Similarly, a corporate liability claim cannot be sustained against Thomas Jefferson University Hospital. With respect to corporate negligence, the Pennsylvania Supreme Court explained that:

> Corporate negligence is a doctrine under which the hospital is liable if it fails to uphold the proper standard of care owed the patient, which is to ensure the patient's safety and well-being while in the hospital. This theory of liability creates a non-delegable duty which the hospital owes directly to the patient. Therefore, an injured party does not have to rely on and establish the negligence of a third party.
> Thompson, 527 Pa. at 338, 591 A 2d 707 (footnote is omitted).

The hospital's duties have been classified into four categories:
(1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment; (2) a duty to select and retain only competent physicians; (3) a duty to oversee all persons who practice medicine within its walls as to patient care, and (4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients. . Id. (citations omitted); Hrg. at Tr. at 4.

To establish a prima facie case of corporate negligence, the plaintiff must prove: (1) one or more of the aforementioned duties of care; (2) the hospital had actual or constructive notice of the defects or procedures that created the harm; and (3) that the conduct was a substantial factor in bringing about the harm. See Whittington v. Episcopal Hospital., 768 A 2d 1144, 1149-50 (Pa. Super 2001). As with a claim of medical malpractice, a claim of corporate negligence requires that "the plaintiff present expert testimony that the hospital's acts deviated from an accepted standard of care and that the deviation was a substantial factor in causing plaintiff's harm." Welsh v. Bulgar, 548 Pa. 504, 51214, 698 A 2nd 581, 585 (1997); Hrg. at 5. Dr.Felder, Plaintiff's only expert never concludes, suggests or in any way insinuates that TJUH breached a standard of care. Doc 78 at 4 see generally Dep. Tr. Hrg. Tr. at 6. At no point does Dr.Felder mention any duty breach of that duty, or any negligent conduct on the part of TJUH. Id; Hrg. Tr. at 7. Further, when asked by the Court what if anything. Dr.Felder concluded with respect to the duty of care owed and allegedly breached by TJUH, Plaintiff could point to nothing in the videotape trial testimony transcript or any evidence he presented. Id. at 17-8, 20-21. The only tenuous connection, the encounter form,

does not remotely suggest that TJUH comported itself in a way that deviated from an accepted standard of care such that its deviation was a substantial factor in causing Plaintiff's harm. Id. As such, the corporate negligence claim fails.

V. CONCLUSION

For all of these reasons, the Motion as a Matter of Law filed by Thomas Jefferson University Hospital ("TJUH") (Doc. 79) and the Motion for Judgment as a Matter of Law filed by Defendant Elliot L Mancall, MD ("Dr.Mancall") (Doc 80) are GRANTED.

BY THE COURT

/script LDD

_____

Legrome D.Davis Jr.

Substantial Deviation from Good Juridical Practices,
Errors by the DC Level & Appellate 3rd Cir: also A171-2

Departures from Accepted Practice and Errors Are:
DC Court-Eastern Pa.-The Honorable Legrome Davis
Case 01-5355 Dismissed without prejudice 8-30-04
Details Follow:
The Court did not understand that an Ankylosing Spondylitis claim is MINE-Medical Improvement Not Indicated by SSA DI 280 40.001 Par. 416.99. The 5-10-04 dismissal as a Rule 50 Matter of Law spent much time opining on the lack of causation. The federal law defines the disease process as incurable. The 3rd Circuit Appeals doesn't have a stare decisis on Ankylosing Spondylitis;however, the 5th Circuit 95-60433 by CHIEF: POLITZ: pp. vi defines the disease, its causality and major manifestations. The expert witness-Diplomate Felder MD-Neurologist made it abundantly clear that symptomatology is the treatment goal. A.113 pg. 110 ln. 20 onward
On A. 96, the expert witness explained that Dr.Mancall had knowledge of the extreme musculoskeletal limitations. [A. 96 pp. 32, 33; A.97 through A. 128] The DC erred. The Trial Court asked the parties to keep the trial under 3 weeks. This request caused economies in the presentation that precluded a proper presentation for a Pro-se litigant. The Court never considered Brophy v. Brizuela-criteria of OBVIOUSNESS opined by Diplomate Deng in an Amicus Curiae Brief to the 3rd Circuit and 5-4-04 appearance at trial. A. 33-43 -Appellate Docket: 22 Metzelfelt may be applied when a case is UNOBVIOUS. Neither Metzelfelt nor Brophy v. Brizuela provide any uniform method of determining UNOBVIOUSNESS. Therefore, the law is murky at best by "Felder v.Casey" and classic federal rights are abridged pertaining to the 1st, 7th, 14th and 21st amendments. The Court confused causality of the disease process which is incurable with the relationship between the negligence and the harm to the patient by any common sense rationale. A171-A172

The case was originally filed on or about 9-7-2001 in the Court of Common Pleas in Philadelphia. It was transferred to the DC for Eastern Pa.under a "diversity" ruling; however, the in depth knowledge of the Pennsylvania statutes resides in the Court of Common Pleas. The case was transferred out by O'Brien & Ryan(TJUH) under the guise of "diversity" because federal juries are drawn statewide. This wider sampling results in lower jury awards because suburban jurists tend to award less money than Philadelphia juries. DC Docket 1-6
Docket 6 is a DENIAL for REMAND by The Hon. Schiller. This farming of cases from the Court of Common Pleas to the federal jurisdiction clogs the federal dockets without any rational cause except to save insurers money.
The Petitioner was DENIED an Order to Compel the TJUH to produce the testimony on the federal law requirement for a Compliance Officer as per Fed.Register Vol.63 #35 MONDAY 2-23-1998 P. 8990. On 2-10-03, Dean Nasca of the Jeff Medical College testified to a House Committee that the clinical revenues of the physician practice derived from the payments to Dr.Mancall) subsidize the college teaching. This may have caused the lack of follow-up by Dr.Mancall and his unknown medical student.

The DC Court approved many Trial Exhibits offered as evidence during trial; however, it is not clear whether or not the Court prepared and audited the evidence forms. see- xvi
The Appellate Court did not apply EADDYS at 694 which is the relaxed standard on the connection of risk to the physician negligence Ankylosing Spondylitis, like cancer, is highly treatable if discovered early. "Overall, the first 10 years of disease is particularly important with respect to subsequent outcome." A. 113 Pg. 114 ln. 21
The Amicus Curiae Brief of Diplomate Deng was not awarded sufficient weight despite the fact that it proves the musculoskeletal issues during July of 1996. In addition, the Appellate Court did not understand the inapplicability of causality to Ankylosing Spondylitis. A. 33 to A. 43

Relevant Portions of the District Court Docket
Pertinent to a United States Supreme Court Review

The following portion of the District Court docket of Case 01-5355 in the District Court were carried forward for review in Case 04-3133 in the 3rd Circuit Court of Appeals. The Appellant pro-se requests that the United States Supreme Court review these portions of the DC docket at such time as this case is taken up for review at the Writ of Certiorari stage or during and subsequent to any oral arguments scheduled.

Docket #	Contents
6	Order DENYING plaintiff's remand of the case back to the Court of Common Pleas where the case was filed originally
12	Complaint
23	Case reassignment from Judge Schiller to Judge Davis
26	Motion to Compel testimony of TJUH
27	Expert letters including 11-22-02 letter of Diplomate Felder MD faxed to Court Chambers of Judge Davis Trial Exhibits 142-145
32	1-13-02 Partial Summary Judgment lack of audit trail of medical record due to medical student not listed (allegedly took the medical history)
38	Plaintiff Summary Judgment Opposition -approved and trial scheduled
45-47	Plaintiff Opposition to Defendant SJ and Court Order Denying Defendants SJ
59,64,65,69-73	Motions in Limine
64	Plaintiff requests Court to de-Classify Daubert criteria and accept obviousness of the disease process ankylosing spondylitis

Docket #	Contents
74	Trial exam transcripts and video for Diplomate Felder MD-Plaintiff Expert
75	Trial Exhibits 1-300 of Plaintiff
76	Trial Exam of Dr.Kellman MD-Internist treating physician with transcript & video
77	Exhibits 91-96 for Trial and transcripts plus video of Dr.Waterman MD-Rheum. from the UCONN
83,84	Opposition Motions by Plaintiff to a Defendants' series of Motions to Dismiss as a Matter of Law
85	Rule 50 transcript of proceedings
86	Granting of Motions as a Matter of Law
87	Plaintiff's Request for Reconsideration
90	Denial of Motion for Reconsideration
92 on	Final Denial of Motion for Reconsideration WITHOUT PREJUDICE and Court states that it is too late to act since the issue has been joined in the Appellate Court
	(34 page brief with tables separately itemizing defendant's breaches, causal connections etc.

United States Court of Appeals 3rd Circuit
Case No. 04-3103
NOT PRECEDENTIAL

Joseph S. Maresca- Appellant Pro Se

v.

Elliot L Mancall MD and
the Thomas Jefferson University Hospital-Appellees

On Appeal from the United States District Court for Eastern District of Pennsylvania DC Civil 01 cv 5355
District Judge-The Honorable Legrome D. Davis

Submitted Under Third Circuit L.A.R. 34.1a 6-8-2005
Filed 6-16-05
Before : Rendell, Fuentes and Garth, Circuit Judges

Opinion

Joseph S. Maresca appeals from the District Court's order granting judgment as a matter of law in favor of the Defendants in this action alleging medical malpractice. For the following reasons, we will affirm the District Court's order. On 12-5-96, Joseph Maresca consulted Dr. Elliot L Mancall, a licensed neurologist in Philadelphia.

Dr. Mancall examined Maresca, diagnosed him with chronic headaches, and prescribed a muscle relaxant. In Sept., 1999, nearly three years later, a rheumatologist diagnosed Maresca with ankylosing spondylitis (AS) for which he continues to receive treatment. Maresca filed a pro-se complaint in the Court of Common Pleas of Philadelphia County against Dr.Mancall and Thomas Jefferson University Hospital alleging medical malpractice based on the failure to diagnose AS or followup after the office visit in 1996. The Defendants removed the case to the District Court, and following discovery, moved for summary judgment. The District Court denied the Defendants motion for summary judgment, and the matter was calendared for trial by jury. In preparation for trial, the parties videotaped the testimony of Maresca's sole medical expert, Dr. Mitchell S. Felder. At the close of Maresca's case-in-chief, the Defendants renewed their previously filed Motions for Judgment As A Matter of Law under Federal Rule Civil P. 50. The Defendants argued that Dr. Felder failed to offer expert testimony from which the jury could conclude that the defendants breached a standard of care or caused any injury to Maresca.
We have appellate jurisdiction under 28 U.S.C. Par 1291.
We exercise plenary review over the District Court's decision to grant judgment as a matter of law.

See La Verdure v. County of Montgomery , 324 F.3d 123, 125 3d Cir. 2003).

> A court should grant such a motion only ' if , viewing the evidence in the light most favorable to the nonmovant & giving it the advantage of every fair and reasonable inference, there is insufficient evidence from which a jury reasonably could find liability. "
> Northview Motors Inc. v. Chrysler Motors 227 F . 3d 78, 88 (3rd Circuit 2000)
> (quoting Lightning Lube, Inc. v. Witco Corp., 4 F. 3d 1153, 1166 (3d Cir'93)

After conducting a lengthy hearing, the District Court agreed and subsequently denied Maresca's timely motion for reconsideration. Maresca appeals. In Pennsylvania, a plaintiff seeking damages for medical malpractice must "establish" a duty owed by the physician to the patient, a breach of that duty by the physician, that the breach was the proximate cause of the harm suffered, and that the damages suffered were a direct result of the harm. "

Too good v. Rogal , 824 A 2nd 1140, 1145 (Pa. 2003)

To establish a breach and causation, a plaintiff must present an expert witness who will testify, to a reasonable degree of medical certainty of the breach and proximate cause.

Metzelfelt v. Kamrin, 584 A 2nd 888, 892 (Pa. 1990)

We have reviewed the testimony of Maresca's sole medical expert in its entirety and agree with the District Court that his testimony does not satisfy these requirements. Dr.Felder did not articulate an opinion to any degree of medical certainty that either Dr.Mancall or the hospital breached any standard of care or caused harm to Maresca. In the absence of such testimony, the District Court was bound to grant judgment as a matter of law in Defendants' favor which we affirm as follows:

And now this 7 day of May 2004, it is hereby ORDERED that the Motion for Judgment as a Matter of Law filed by Thomas Jefferson University Hospital ("TJUH") (Doc. No. 79) and the Motion for Judgment as a Matter of Law filed by Defendant Elliot L Mancall ("Dr.Mancall") (Doc. 80) are granted with prejudice. Pursuant to Rule 41. 1(b) Local Rules of Civil Procedure, it is further ordered that this matter be dismissed with prejudice . The Clerk of the Court is directed to statistically close this matter.

The grant of summary judgment and dismissal of the complaint are inconsistent. Cheminor Drugs Ltd. v. Ethyl Corp. 168 F. 3d 119, 121n 2(3d Cir. 1999) In any event, see Local Rule of Civil Procedure of the Eastern District 41.1(b)

In the absence of such testimony, the District Court was bound to grant Judgment as a Matter of Law in the Defendant's favor.

We are aware of Maresca's continued attempts to rely on Dr.Felder's report dated 11-22-2002. We are also aware that the District Court also repeatedly informed Maresca that Dr.Felder's report , while sufficient to defeat the Defendant's Motion for Summary Judgment was never admitted into the trial record and thus could not be considered by the jury. At bottom, regardless of what his report states, Dr.Felder's testimony did not provide sufficient evidence from which the jury could have found in Maresca's favor on two essential elements of his claim. For these reasons, we affirm the District Court's order granting judgment as a matter of law in favor of the Defendant's. We deny the motion by Charles Deng pertaining to settlement rather than adjudicated cases. Proceed as amicus curiae. Fed. R P. 29 (b) Neontology Associates 293 F. 3d 128 (3rd Cir. 2002)

Substantial Deviation from Good Juridical Practices by the Appellate 3rd Circuit 04-3103 Rendell, Fuentes, Garth

The the case was transferred wrongly from the Court of Common Pleas, Phil. to the District Court-E. Pa. under the guise of "diversity" and in direct variance with the spirit of the 11th Amendment which limits automatic jurisdiction of federal courts to automatically hear cases including citizens between states as in this case. DC Docket 1 onward. The 11th amendment was designed to prevent a citizen from one state from bringing suit against another in federal court. Art. 3 Sec.2 modified; Chisholm v.Georgia 2 U.S.419 1793

The Appellate Court failed to give due consideration to EADDY at 694 which requires only a causal connection between the risks and the physician's harm. EADDY 694 has been applied to cancer cases ; however, there is application here because the Petitioner is alive 10 years after the first symptomatology on 12-5-96. In medicine, management of a disease process 5 years after discovery is considered in the nature of a cure. On A. 113, Diplomate Felder testified that the treatment goal is to alleviate symptoms and that " the first 10 years of disease is particularly important with respect to subsequent outcome." The work Diplomate Felder MD-Neurologist performed is on A.87 to A. 114. The tremendous risks of stroke, vascular problems and suicide are outlined on A. 134- a professional literature reference from the New England Journal of Medicine. Diplomate Felder affirmed conclusions in a 11-22-02 letter. " I would say I still hold those conclusions"A.113,A135-43 The expert witness affirmed that the Petitioner had the considerable risks of non-treatment for ankylosing spon. from 12-5-96 (the date of Dr.Mancall's exam) to 9-15-99, the date of discovery of the ankylosing spondylitis. The Petitioner brought a memo to Dr.Mancall on 12-5-96 describing the inability to do a sit-up or run . A.124-A.125. The Petitioner's testimony is that Dr.Mancall dissuaded him from a diagnosis involving the spine. "No.No. Don't touch the spine. " A.28-A.32 Diplomate Deng placed the spinal rigidity in the 7/96 time period- a full 5 months preceding Dr.Mancall's exam. A.33-43 including Amicus Curiae Brief and a personal appearance at trial by Diplomate Deng. 5-4-04

United States Court of Appeals for 3rd Circuit
No. 04-3103

JOSEPH S. MARESCA
APPELLANT

v.

ELLIOT L. MANCALL MD
THOMAS JEFFERSON UNIVERSITY HOSPITAL

On Appeal from the United States District Court
For Eastern District Pennsylvania
(D.C. Civil No. 01-cv -5355
District Judge: Honorable Legrome D. Davis

Submitted Under Third Circuit L.A.R. 34.1(a)
June 8, 2005
Present:Rendell, Fuentes and Garth, Circuit Judges

SUR PETITION FOR A PANEL REHEARING

The petition for rehearing filed by appellant having been submitted to all judges who participated in the decision of this court, and no judge who concurred in the decision having asked for a rehearing, the petition for rehearing is hereby DENIED.

BY THE COURT:
/s/Marjorie O. Rendell
Circuit Judge

Dated: December 19, 2005
DMM/cc: Mr. Joseph S. Maresca (Pro-Se)
Audrey J. Copeland, Esq.
Michael J. Panichelli, Esq.
Paul E. Peel., Esq.

United States Court of Appeals 3rd Circuit
Case: 04- 3103 Maresca (Plaintiff) v. Mancall MD and
Thomas Jefferson University Hospital TJUH- (Appellees)

Docket Entries: Telephonically with the Court Clerk 2-24-06

1. Docket opened
2. Receipt of the Record
3. Motion to Correct the Record
4. Motion to Amend the Caption by Appellee
5. Extension of Time to File Transcripts
6. Appearance of Michael Panichelli, Esq.for Dr.Mancall MD
7. Appearance of Paul Peel, Esq. of TJUH
8. Disclosure statement of TJUH
9. Motion by Dr.Mancall to Amend Caption
10. 8-11-04 Order Denying Extension of Time
11. Motion for Leave to File Trial Examinations
12. Clerk Motion Granted to Amend Caption of Appellee
13. Clerk Order -Appellant Motion to File Trial Transcript Granted
14. Certified Copy Order to District Ct. for Trial Transcripts
15. Jennifer Haberle-Non-Participation Letter
16. Filing of the Record of the District Court
17. Brief Notice Issue
18. Opposition Filed by Appellees
19. Brief of Appellant filed
20. Notice Telephone Request
21. Completion received

Docket Entries of the Appellate Court 3rd Circuit -
Case 04- 3103 continued

22. Proposed Amicus Brief of Diplomate Charles Deng
23. Clerk Order Referring the Motion to Merit Panel
24. Brief of TJUH
25. Appearance of Audrey Copeland, Esquire
26. Brief of Dr. Elliot L Mancall MD
27. Motion for Extension of Time-Reply Brief Appellant
28. Order Granting Reply Brief
29. Motion for Extension of time for filing Reply Brief-Appellee
30. Clerk's Order Granting Motion for Extension of time for filing Reply Brief-Appellee
31. Transcript purchase order form
32. Transcript Scheduling Order
33. Part 2-Court Reporter Purchase Order Form
34. Part 3- Purchase Order Court Reporter
35. Appellant Filing for Extension of Time for Court Reporter Transcripts
36. Clerk's Order Granting the Motion
37. Supplemental Appendix by the Appellant
38. Order Granting Supplemental Appendix
39. Supplemental Appendix Filed

United States Court of Appeals 3rd Circuit 04 - 3103
Docket Entries-continued

40. Reply Brief Filed
41. Case Opposition
42. Judgment Order
43. Bill of Costs for Appellee-Dr.Mancall MD
44. Non-Compliance Motion Filed -Exhibits for Petition to Rehear
45. Appellant Motion to File Exhibits.-Petition to Re-hear by the Merits Review Panel
46. TJUH response
47. Order Denying Appellant Motion for Leave to File Exhibits
48. Petition to Rehear Filed
49. Mandate Issued 12-19-05
50 Record Returned

(2)

Supreme Court, U.S.
FILED

051485 MAR 16 2006

OFFICE OF THE CLERK

No.

Supreme Court of the United States
1st Street N.E. DC 20543-Clerk Office
202-479-3011

Joseph S. Maresca- Petitioner-Pro Se

versus

Dr. Elliot L Mancall MD Respondents
Thomas Jefferson University Hospital

On Petition for a Writ of Certiorari
Appendix- BOOK II

To the Court of Appeals 3rd Circuit: 04-3103
(Rendell, Fuentes, Opinion by Garth
on 6-8-05 ;issued 6-16-05
Reconsideration Denial 12-19-05; Writ Due 3-20-06)

Joseph S. Maresca-Pro Se- PETITIONER
Of Record
Bronxville, NY 10708-0646
914-649-3817

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BOOK II OF II

BOOK II

APPENDIX

A. 28-32	Excerpts of Plaintiff-Trial Testimony 5-3-04.
A. 33-39	5-4-04 Trial Exam of Diplomate Deng by personal appearance before the Court & jury. Trial Exh. 12-Admitted 7-6-1996 acupuncture observations of head,neck, shoulder and spinal stiffness
A.41-3	Amicus Curiae Brief to 3rd Circuit Appellate by Diplomate Charles Deng-Acupuncturist
A.44-54	7-24-02 Deposition of Dr.Mancall MD filed with the Trial Court and cited in an 11-22-02 Expert Letter of Diplomate Felder MD-Neurologist and Psychiatrist
A. 55	Thomas Jefferson University Hospital(TJUH) counsel filing of a Corporate Charter with the Secretary of State of Pa. which places the Jefferson Medical College-College and Faculty in the TJUH, Inc.
A.57-71	Trial Exam played by Video before the Court and Jury on 5-4-04 for Dr.Waterman MD-Rheumatologist.
A.66	Trial Exhibit 93 encounter form Dr.Waterman
A.67-9	Letter of 9-15-99 to Dr.Kellman MD-Internist used as a fair measurement date for the Statute of Limitations discovery of Anky. Spondylitis
A.70-1	Spinal x-ray of 9-9-1999 found Anky. Spon.
A.72-82	Trial Exam of Dr.Kellman MD-Internist played by video 5-4-04 with transcript filed with the Trial Court
A.80-1	Pre-Diabetic glucose & blood yeast saturated
A.77-89	Various treatments for internal inflammations and blood tests including normalization of glucose levels in the year 2000.

APPENDIX-CONTINUED

A.83-143 Trial Exam of Diplomate Felder MD-Expert Witness Neurologist and Psychiatrist video and transcript created 1-16-04 and played at trial 5-4 and 5-5-04.

A.115-17 Trial Exh. 43-44 Thomas Jefferson Univ. encounter form-Approved by Trial Court

A.120-3 Plaintiff memos to Dr.Mancall (Defendant) in Feb. 1997 complaining of pulling in facial mask and correct interpretation of a Brain MRI delivered to Dr.Mancall 2/97. Trial Exhibits 46-48-Approved by Trial Ct.

A. 124-5 Exh. 49 -memo brought to 12-5-97 encounter which Dr.Mancall admitted to reading in his deposition. The memo describes musculoskeletal issues and an inability to do a sit-up or run

A. 126-28 8-17-1991 MRI of lumosacral spine showing a disk disease at L4 L5 -S1 levels -Exh. 50. 51

A. 129-30 Drs.Terraciano and Dr.DeCarlo findings of Iritis, a marker for Ankylosing Spondylitis in 5-20-97 time frame.

A131-2 Dermatologist encounter form with note "iron hand on scalp pulls upward-3 years" by Diplomate Abel MD with note to see a Rheumatologist-Dr.Abel MD noted the facial pulling in the 12-5-96 examination of Dr.Mancall MD (Defendant)

A.133 Pathology report of Dr.Dworkin MD-Surgeon findings of Crohns 12-20-91 noted in Dr.Mancall's encounter form 12-5-96

A.134 Article on Mortality Among Patients with Ankylosing Spondylitis Not Given X-ray Treatment VOL. 297 7: 572-7 9-15-77 New England Journal of Medicine cited as per Civil Rule 803.18 with attributions to other authors citing this article

APPENDIX - CONTINUED

A135-143 Diplomate Felder MD-Expert Letter taken under Advisement for evidence by the Trial Court

A.144-60 Dr.Lee MD, PhD treating physiatrist did the Schober test and comparison x-rays 2001-1999 A156-160 Trial Exhibits 97-100 approved by the Trial Court

A. 161-65 Expert Rheumatologist for the Defense Letter by Dr.Epstein MD and A. 164 containing a statement by Dr.Epstein MD placing the disease in the 1995 to 1996 time frame.

A. 166 on Legal Discussion of Questions Presented for Review

TABLE CONTENTS (SUB-APPPENDIX FOR WRIT) TESTIMONY AND TRIAL EXH. RECONCILIATION OF WRIT OF CERTIORARI TO THE APPELLATE CT. 3RD CIR. RECORD APPENDIX & DC TRIAL EXHIBITS
In the Writ of Certiorari, the Respondent utilizes some exhibit numbers in the sequence of the District Court-Trial Exhibits provided the Court in duplicate numbers 1-300. This record might be called subsequent to oral arguments.

These exhibits are contained in the writ because the Trial Court record & 3rd Cir. Appellate must be ref. in the Writ.

Description	Trial Exhibit	Supreme Court-APP.
Diplomate Deng	12	A. 39, A 40
Dr.Mancall MD Defendant	Trial Exh.43-53 ;55	A 115-128
Letter brought to Dr.Mancall exam of 12-5-96 by patient	49	A. 124, A 125
Dr.Waterman MD Rheumatologist	94, 95	A. 67-69
Dr.Abel MD Dermatologist 7-28-99 encounter	135	A.131.132
New England Jour. of Medicine on Anky. Spon. Mortality by Radford et al.	Exh. 279	A. 134

Description	Trial Exh.	Supreme Court APP.
Diplomate Felder MD Expert-Neurologist	142-5 in DC 76-9 3rd Cir. APP	A135-143
Dr.Epstein MD Defense Expert	153-5	A. 161-165
Thomas Jeff, Univ Encounter form of Dr. Mancall MD	Exh. 43 A.008 in 3rd Cir.	A. 115-116
Drs.Terraciano & Dr.Joseph DeCarlo MDs (Opth.-Iritis Findings)	Exh. 112, 114	A 129, 130
Dr.Dworkin MD Surgeon discovered Crohn's Disease 12/91	A. 117, 118	A. 133

Trial Testimony of Diplomate Felder MD-Neurologist
1-16-04 played on 5-4-04 and 5-5-04

Transcript Page- 3rd Circuit APP	Supreme Court APP
107 p. 12 ln.7	A 87
108 p. 13,14	A88, 89
112 p. 32 ln. 11	A96
118 p. 54 ln. 5-21	A 106, A 107
120 p. 63 ln. 17 onward	A 110, A111
121 p. 66 ln. 13-21	A 111, A112
133 p. 115 ln. 3-15; p116 ln.1-8	A113, A114
A. 311 p. 37 ln. 9-19	A 98

IN THE UNITED STATES DISTRICT COURT FOR
EASTERN DISTRICT OF PENNSYLVANIA
JOSEPH S. MARESCA CIVIL ACTION
v.
ELLIOT L. MANCALL, MD, et al. NO. 01-5355
Philadelphia , Pennsylvania
May 5, 2004

BEFORE: HONORABLE LEGROME D. DAVIS, JR.

TRIAL EXAMINATION OF JOSEPH S. MARESCA
EXCERPTS

APPEARANCES:
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BOX 646 BRONXVILLE, NY 10708

FOR DR.MANCALL: BRADLEY GOEWERT,ESQ.
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PHIL. PA. 19103

FOR THOMAS JEFFERSON UNIVERSITY HOSPITAL: DOROTHY DUFFY, ESQ.
O'BRIEN AND RYAN
HICKORY POINTE
2250 HICKORY ROAD
SUITE 300
PLYMOUTH MEETING
PA. 19462-1065

COURTROOM DEPUTY: MARCELLA EL SHABAZZ

Page 160 Questioning by Mr. Goewert, Esq. for Defendant

ln. 1 Q. Anything during the visit you wanted to show me that you made up?

A. I made a diagram of what I can recall the examining room looked like. I better use this, because I don't have my copy readily available. The doctor was standing right in front of the table. I was seat on the table.

This could have been one of the problems. Dr.Mancall performed his examination. He did similar to what he did in 1991. He utilized those little hammers. I know he looked into my eyes with the physician's headgear and light. I know he also looked into my mouth. We had a discussion about what I was there for, the nature of the tension, and I described to him the tremendous pulling & discomfort. And going beyond that, I walked over to the wall and tried to press the back of my head to the wall and it would not. I know that I also

Page 161

ln. 1 A. laid on the floor and did a similar demonstration to the one that I did with the resident medical provider or assistant.

Q. Are you sure about that?

A. Yes

Q. As you sit here today in 2002, you're sure about that?

A. Yes, because it was very strange, I felt that the head was protruding.

Q. So you felt in 1996, December 5, 1996 during this visit, that you had this protrusion forward of the head that was some abnormality to you right?

A. Yes

Q. Didn't seem normal to you right?

A. Well, I detected it in doing the exercises. I was made acutely aware of it when I did the exercises. I really hadn't realized what it was until I did the karate and I started to find out what some of these limitations were.

Q. So you knew you had these limitations and that was part of what you were trying to find out is why you had these limitations back December 5 of 1996, is that right?

A. That's correct.

Q. What happened next?

Page 162 continued

ln. 9 A. Dr.Mancall continued his exam. He questioned me, and this, I think might have been one of the problems. I don't recall that when I was on the examining table--see, my feet were over like this and I was sitting on the edge of the examining table like this (indicating).
But I don't think he actually laid me down at 180 degrees where he could have seen the protrusion of the head. I don't recall that he laid me exactly 180 degrees flat, although he might have, but I don't recall that he had me in a 180 degree flat position on the examining table where he could observe the leaning forward.

Page 163

ln. 2 Q. You showed him on the wall right?

A. Yes.

Q. And I think you said you sat on the floor and showed him on the floor, right.

A. Yes

Q. So you would have laid on the floor and showed him just like you did us?

A. Yes. But on the examining table if you're examining someone, it's a little bit more of a dynamic.

Q. What happened next?

Page 163

ln. 16 A. At some point, I brought up about the spine and he walked over maybe to the wall. And when I brought up the spine, it was almost like a holdup. He put his hands up in the air and he said: "No, no, don't touch the spine." He said it in like a whine, and I really didn't question it beyond that. I know there was a little discussion about the spinal. He may have theorized that the gravity--

Q. My question to you is very simple. What happened? Now you're giving me theories of what's in his mind.

A. No, this is really--

Q. That's really not my question.

A. --what he explained. He did some explanation to me about why that might be.

Q. Why what might be?

A. The--whatever problem I had with the spine. He felt that maybe gravity would make that worse, the forces of gravity. He said we're primates and forces of gravity might impact the spine.

IN THE UNITED STATES DISTRICT COURT FOR
EASTERN DISTRICT OF PENNSYLVANIA
JOSEPH S. MARESCA CIVIL ACTION
v.
ELLIOT L. MANCALL, MD, et al. NO. 01-5355
Philadelphia , Pennsylvania
May 4, 2004

BEFORE: HONORABLE LEGROME D. DAVIS, JR.

TRIAL EXCERPT-TESTIMONY OF DIPLOMATE DENG

APPEARANCES:
FOR PLAINTIFF: JOSEPH S. MARESCA, PRO-SE
BOX 646 BRONXVILLE, NY 10708

FOR DR.MANCALL: BRADLEY GOEWERT,ESQ.
1845 WALNUT ST.
PHIL. PA. 19103

FOR THOMAS JEFFERSON UNIVERSITY HOSPITAL: DOROTHY DUFFY, ESQ.
O'BRIEN AND RYAN
HICKORY POINTE
2250 HICKORY ROAD
SUITE 300
PLYMOUTH MEETING
PA. 19462-1065

COURTROOM DEPUTY: MARCELLA EL SHABAZZ
TRANSCRIBED BY: DRUMMOND TRANSCRIP
HADDON HEIGHTS, NJ. 8035
PROCEEDINGS RECORDED BY ELECTRONIC SOUND RECORDING. TRANSCRIPT BY TRANSCRIPT SERVICE.

(Excerpt of trial-testimony of Charles Deng, 5-4-2004)
THE COURT: Up here, please sir.
COURTROOM DEPUTY: Good afternoon, sir.
THE WITNESS: Good afternoon.
COURTROOM DEPUTY: Please state your full name, and spell your last name for the record.
THE WITNESS: D-e-n-g.
COURTROOM DEPUTY: Please raise your right hand. You do swear, and/or affirm, that the testimony you're about to give before this Court will be the truth, the whole truth, and nothing but the truth so help you God, or you do so affirm?
THE WITNESS: Yes, I do.
COURTROOM DEPUTY: Thank you.
CHARLES DENG, sworn.
THE COURT: You may proceed sir.
[Note: Mr.Maresca is not speaking into a microphone.]

By Mr. Maresca:
Q. Good morning, Diplomate Deng.
A. Good morning.
Q. Thank you very much for traveling the long distance here.
A. You're welcome.
Q. If you would please state your full name for the record.
A. My name is Charles Deng.
Q. Could you spell that please?
A. C-h-a-r-l-e-s last name D-e-n-g

Q. And do you have a middle name?
A. No
Q. Okay, and Charles what is your occupation?
A. Acupuncturist.
Q. Also, if you could give me an address where you live, your residence or business address?
A. Yes, now I'm working in Forrest Hills, Queens.
Q. And the address?
A. Address, 10251 Queens Boulevard, Forrest Hills, NY
Q. Mr. Deng, if you could-are you a licensed acupuncturist?
A. Yes. I'm a New York licensed acupuncturist.
Q. And what does that entail, a licensed acupuncturist? Did you have to pass an exam?
A. Yes, I had to pass the Board exam, and then I have to provide the documents of my educational background, and pass the English proficiency examination.
Q. Okay, Diplomate Deng, do you have a background in-- or have you passed courses in anatomy?
A. Yes
Q. Physiology
A. Yes.
Q. Pathology
A. Yes
Q. Have you had courses in clinical acupuncture?
A. Yes
Q. Diplomate Deng, are you a diplomate?
A. Yes
Q. What does a diplomate involve? How does this distinguish you from a regular acupuncturist?

A. Diplomate is a regular acupuncturist. Now in New York State there are two kinds of acupuncture certified, one is the certified acupuncturist which means it has the medical background, education, like a medicine doctor, dentist, and they have only to take 300 hours of training, then they got certified as an acupuncturist. That's called certified acupuncturist. It's having a certificate.
Q. And for the diplomate?
A. The acupuncturist has to be --that's a licensed acupuncturist, which means they're originally trained in the Chinese medicine system, and that's the difference.
Q. Okay, And in achieving the diplomate status, how did you achieve that, did you take a formal exam to become a diplomate?
A. Yes. I passed the National--NCCA examination--that's a NCCOM.
Q. And what distinguishes that examination from a regular accupuncturist examination?
A. That's required much more in detail, in background education, in training with the Chinese medicine system.
Q. Okay, Diplomate Deng, do you have clinical experience with conditions of the spine?
A. Yeah.
Q. Was that clinical experience derived from your training as an acupuncturist?
A. Yes.
Q. Okay. Diplomate Deng, I would like to get into when I first had an appointment, or a meeting, with you in your offices, and I would like to show you some records.

Q. continued First this-- Plaintiff's Exhibit No. 12 dated July 6. 1996. Sir , is that your record?
(P-12 office record of Diplomate Deng on Joseph Maresca dated 7-6-96 marked for identification.)
A. Yes
Q. And if you could explain to the jury, briefly, everything that you did on that date, everything you observed on that date?
A. That's the first date--the first time I see Mr.Maresca, and he came to my office--which means that's the office, the old office and old address, that's in 133 Bowery, in Chinatown. And on that day he come to me asking for help for his overweight problem and pain, stiffness of neck, shoulder which was caused by muscle spasm . And after I check up with him, I found he has a limitation of mobility of the spine, and the neck, and the lower back. It's really limited on his vertical area. He only can turn his neck on left side five degrees or so, ten degree on the right, and almost--almost cannot sit down by himself. You need to hold out the chair and then I could make it "firm". (ph.) And also by the time I check up with him on the bed, he couldn't lie down by himself, I'm holding his back to put him down. And after I check up with him, I found he has redness of face, he's sweating and hyper-liver yang condition. His chief complaint-he has a headache, and pain and stiffness on the neck and shoulder, and repeating this problem. And on that day, I give him a suggestion. I told him I couldn't help to change his condition by acupuncture,
and suggest him to see the medicine doctor to have a further checkup and find out the necessary treatment. So that's the first day. I see him. It's the first image.
Q. Diplomate Deng, from the first visit, do you recall, did you turn the patient's head to the left

A. I'm sorry, I didn't catch that.
Q. Did you turn the patient's head to the left?
A. Yeah, I check.
Q. And what did you find?
A. On the left, he's very limited, it's only like 5 degrees of turning, and then turning it back to the right side, in the (indiscernible) position, he only can turn about 10 degrees.
Q. Diplomate Deng, did you ever at any time have the patient lying flat on the examination table?
A. Yes, I did.
Q. And in the patient lying flat on the examination did you notice anything in particular?
A. His head couldn't touch on the back flatly like the other--like normal people lie down. So I have to put--double up the pillow under his neck to support his head.
Q. Is it your testimony that you had to put a double pillow under the plaintiff's head so that it would rest comfortably; is that your testimony?
A. Yes
Q. And Diplomate Deng, did that condition ever change?
A. No.

Analysis: The testimony of Diplomate Deng-Acupuncturist comports with the Brophy v. Brizuela criteria which requires obviousness of the disease process to an ordinary person. In this case, Diplomate Deng has attested to gross range of motion conditions present during 7/1996 ; such that a reasonable person could infer the need for substantial treatment and ongoing medical care. No person (after seeing the presentation of this patient) could infer that no medical treatment would be necessary.

Trial Exhibit 12

Charles Deng, NYS Lic. Acupuncturist
133-B Bowery NY, NY 10002
Tel. 212 966 8431 Date 7-6-96
Patient Information Initial Visit

Last Name: Maresca First Name: Joseph
Box 646 Bronxville NY 10708
Age: 44 years Sex: M DOB 1-14-52 Marital: S

CHIEF COMPLAINT AND HISTORY PRESENT ILLNESS
Chief Complaint: Pain and stiffness at head,neck,shoulders
What treatment has been taken for current problem:
Physical Therapy

PHYSICAL EXAM
Overweight, presently 241 lbs. Blood pressure: 135/80
2. limited spinal movement, 3-muscle spasm at neck, shoulders and upper back Respiratory: 82/min.
Temperature:Normal

Major questions and Pulse Status:There is no recent injuries to his neck, shoulders and upper back. There is no infections known to the patient. The patient's pulse is floating and strong, red tongue and yellowish coating. Fair energy and spirit.

1) upper and hyper liver yang
2) Yang min headache
3) Muscle spasm
4) Ossification of the ligament need to be confirmed in the future check-up. Patient is recommended to see the MD for further check-up.

Trial Exhibit 12- Continued

Initial treatment plan:
Lower the liver-yang by improving the kidney and liver ying energy and detoxify the liver and blood system.
Relieve the muscle spasm by acupuncture.
Balance ying-yang of kidney and liver.

WE, THE UNDERSIGNED DO AFFIRM THAT THIS PATIENT HAS BEEN ADVISED BY A LICENSED ACUPUNCTURIST TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

PATIENT SIGNATURE: Joseph S. Maresca 7-6-96
ACUPUNCTURIST SIGNATURE: Charles Deng 7-6-96

Third Circuit Appellate Court
21400 United States Courthouse
601 Market St.
Phil. Pa. 19106-1790

Case 04-3103 Maresca v. Mancall MD et al.

Amicus Curiae Brief in Support of the Appellant-Maresca
Civil Rule 702

Submission by
Diplomate Charles Deng-Acupuncture
102-51 Queens Blvd. Forest Hills, NY
Witness: 5-4-04 Trial Appearance, 8-20-02 Deposition
11-09-02 Letter

Due Date: 11-01-04

Charles Deng Acupuncture P.C. , L. Ac.
10-13-04
Diplomate Charles Deng
102-51 Queens Blvd. Forest Hills, NY

Comments to the Appellate supporting Joseph S. Maresca under Civil Rule 702

To the Court of Appeals of the 3rd Circuit,
With the Court's permission, please admit this Amicus Curiae
statement which complements trial testimony of 5-4-04, a deposition of 8-20-02 and an 11-09-02 letter. On the first acupuncture visit of 7-6-96, the patient and now appellant Joseph S. Maresca had OBVIOUS spinal problems including the suspension of his head from the examining table while lying flat, stiffness of the head, shoulder, neck and spine, significant resistance in turning the head either left or right and an impression of ossifications. I had similar observations on at least 3 other visits during July 1996 including 7-13-96, 7-20-96 and 7-27-96. In addition, the patient could not rise from the examining table unassisted.

continued

My records also show that from August of 1996 until several years later, the patient did not get the benefit of my treatment while he was pursuing a diagnosis due to my initial suggestion to consult a medical doctor.

In the 8 years since the first visit, these rigidity issues still remain. Acupuncture complements the considerable treatment regimen for ankylosing spondylitis and the patient continues to receive treatments regularly.

Several major USA insurance carriers reimburse the acupuncture procedure.

Respectfully,
Charles Deng
Diplomate in Acupuncture

IN THE UNITED STATES DISTRICT COURT FOR
THE EASTERN DISTRICT OF PENNSYLVANIA
DEPOSITION FILED FOR TRIAL

JOSEPH S. MARESCA — CIVIL ACTION
Plaintiff
v. — NUMBER 015355
ELLIOT L.MANCALL MD
and
THOMAS JEFFERSON UNIVERSITY
HOSPITAL
Defendants

Oral deposition of Elliot L.Mancall MD was taken, pursuant to notice, held at the law offices of Marshall, Dennehy, Warner, Coleman and Goggin, 1845 Walnut St., 21st Fl. Phil. Pa. on Wed. July 24, 2002 beginning at or about 10:35 AM before Debra J. Veneziale
Court Reporter and Notary Public, there being present

APPEARANCES:
JOSEPH S. MARESCA CPA, CISA- PRO SE

MARSHALL , DENNEHY AT AL.
BY STEVEN RYAN , ESQUIRE
REPRESENTING: DEFENDANT ELLIOT L MANCALL MD

O'BRIEN AND RYAN ;BY CYNTHIA L BRENNAN, ESQ.
REPRESENTING :DEFENDANT ,
THOMAS JEFFERSON UNIVERSITY HOSPITAL

WITNESS
ELLIOT L MANCALL MD
EXAMINATION BY MARESCA

EXHIBITS Description and Page Marked

1. Schema of Dr. Mancall's Office 5
2. Explanation of documents 5
2-1. Encounter form of 12-5-96 5
2-2 Prescription for MRI 5
2-3 Report of MRI 5
2-4 2-9-97 NOTE 5
2-5 2-15-97 NOTE 5
2-6 2-26-97 NOTE 5
2-7 Patient Summary of History 5
2-8 Report of 8-17-91 5
2-9 Blood series of 10-31-91
[5] 4 Prescription for MRI of the Brain 5
[6] Encounter form of 8-15-91 Bill of Hahneman Hosp. 5
[7] 6 Encounter form of 7-28-99
Miscellaneous medical records

Excerpts of Dr.Mancall MD's 7-24-02 Deposition filed with the District Court-E. Pa. and cited by the Expert- Diplomate Felder MD-Neurologist in his letter of
11-22-02 and in the trial examination A. 87 and A.135 to 143

Page 8

ln. 22 Q. When did you graduate medical school? A.1952
Q. Was that general medicine?

Page 9

ln.1 A. I graduated medical school with an MD; but it's general medical training
Q. Where did you complete the specialization?
ln.12 A. I specialized in neurology at a number of institutions
ln.14 Q. Where did you do your residency?
A. At the- as I say, at a number of institutions. I began at the National Hospital for Nervous Diseases in London, then the N.Y. Neurological Institute and then the Massachusetts General Hospital

Page 10

ln. 8 Q. Do you have a diplomate in neurology?
A. We do not.

Page 11 and top of Page 12

ln. 23 Q. Sir, if you would very briefly go over the commencement of the exam beginning with the head. Were you able to turn the head freely from the right to the left?

Page 12

ln. 4 A. I did not record any alteration of that. I have no specific personal recollection.
20. Q. As part of your examination did you undertake to move the patient's head from right to left?
A. I have no specific recollection of this particular exam.

ln. 4 Q. Did you at any time place your hand on the patient's neck as part of the exam?

A. I have no recollection of that.

ln. 20 Q. Did you find any rigidity or stiffness in the shoulder?

A. Not that I can recall

ln. 24 Q. Did you examine the spine at all?

ln. 1-2 A. I have no specific note to indicate that I examined the spine on that occasion and I don't recall specifically.

ln.5 Q. At any time did the patient rest flat on the table; in other words flat 180 degrees with every part of the body touching the examining table?

A. I do not recall

ln.10 Q. Do you recall the posture of the head on the examining table? When the patient was lying flat on the examining table, do you recall the posture of the head? Was the head touching the cushion of the table?

A. I cannot recall.

Page 15

ln. 1 Q. Did you touch the neck?

A. I cannot recall/

ln. 18 Q. From your visible observation, was there a deficiency in neck posture? Did the neck posture appear to be correct to you or was there a deficiency in it from looking at the patient?

A. I have no record to indicate that there was a deficiency, and I have no personal recollection of that.

Page 16

ln. 23 Q. Did you notice any spasms in the facial nerve, anything visible?

A. No, there was nothing visible that was recorded.

Page 18

ln.. 12 Q. Did you examine the pelvic area at all?

A. I have no recollection of examining that specifically.

Page 19

ln. 5 Q. Did you examine the hip extensions?

A. Yes.

Q. Did you examine the lateral rotations of the thigh?

A. I have no recollection and I have no note to that effect.

Page 20

ln.12 Q. Did you observe the patient at all either doing a sit-up or getting off the table from a flat position?

A. Not that I can recall.

Q. Did you observe any difficulty in the patient getting off the table?

A. I have no recollection and no record to that effect.

Q. Did you have to help the patient get off the table at any point?

A. I cannot remember.

Page 21

ln. 9 Q. Did you detect any bamboo leaning forward of the spine in your December 5, 1996 exam?

A. I have no recollection to that effect and I have no notes to that effect.

Page 22

ln.7 Q. So I guess you also would not have observed any kyphosis, even a mild kyphosis in that exam?

A. I have no record to that effect.

Q. Did you test the abdominal reflex at all?

A. I don't recall. I commonly do, but in this particular incident, I do not know.

Page 29

ln. 13 Q. Did he discuss at all the pulling of the facial muscles with the medical student and what the medical student's understanding of it was.

A. I commonly discuss the history with the medical student who happens to participate in the exam. I suspect I did, but I have no specific recollection.

Page 35-6

ln,23 Q. The first question is: Would there be any way of identifying the medical student who wrote the upper portion of this record?
(medical encounter form)

A. No

Page 37

ln. 15 Q. go through what you did write (on the encounter form)

A. certainly (by the witness)

Q. So that we can have a complete understanding of what you wrote.

A. All right. I wrote OE which stands for on examination, obese, blood pressure 140/80, mentation check, which means normal. Cranial nerves all normal. Fundi check, which means normal. Motor strength, bulk, tone, check, which means normal.

Deep tendon reflexes which is what PL stands for, plantars are downgoing. Cerebellar function which is spelled CBI on this note, cerebellar function normal. Sensation normal.

Diagnosis, chronic tension headaches. Rule out intraventricular tumor. Plan MRI. If okay, Fiorinal, return post MRI and then that's my signature scrawled down there.

Page 39

ln.10 Q. As an administrative question, how could the State evaluate a candidate's work experience if there name is not on the face of the form? How can a candidate prove that they have the work experience? How can you discourage three or four or five people from claiming the same work experience if the name is not on the face of the form?

MS. BRENNAN AND MR. RYAN : OBJECTIONS.

Page 42

ln. 4 Q. Did you give any specific instructions that you can recollect to one of the secretaries regarding follow-up?

A. Not that I can recall.

Page 43

ln. 1 Q. Did you review this report from the MRI of the Bronx after the MRI (brain) had been taken?

A. Yes

Q. Did you review the actual films?

A. I can only say probably. I have no specific recollection.

ln.20 Q. This is the first letter I wrote to you. It looks like Feb 9th, it's stamped Feb 13th 1997.

Did you read this memo?

A. Yes

Page 44-45

ln. 4 Q. There's a following memo on Feb. 15th , 1997 addressed to you. It looks as though it is logged Feb 24, 1997. In the first paragraph I'm conveying a number of things. There is still some tension in the forehead which worsens at night. And also I'm saying in the opening letter, the opening paragraph: Previously, we discussed that the MRI disclosed what was believed to be a normal shrinkage of the cerebellum and little else. Is that true? sir?

Q. Did you see this letter?

A. Yes

ln. 9 Q. Okay. let's move on. The next letter does not have a date stamp. It is signed by me and it is dated Feb 26th, 1997. And in the first paragraph I mention the Imitrex appears to relieve the tingling in the fingers. However, the tightening of the trigeminal nerve structures continues unabated. And at the end of the second paragraph I'm saying: At most the acupuncture translates a frozen facial mask into smaller pockets of tension. Did you read this letter?

A. Yes.

Page 46-47

ln. 16 Q. Then there was another document which brought to the Outpatient Neurology Clinic. I had given this initially to the medical student and I believe it is in the folder. At the bottom in the last-the next to the last paragraph I have in yellow: There appear to be some permanent restriction in the ability to do a sit-up and to run at maximum speed. That's mentioned in this along with other items. Did you read this memo at all?

A. Yes.

Page 49

ln. 16 Q. Do you recall filling out Exh. 5. this is a receipt for $200. of the exam of the Hahneman Hospital in 1991?

A. Yes

Q. There is a notation by you lumbosacral strain. What would you have meant by lumbosacral strain?

A. Generally speaking, I would have been referring to pain in the low back perhaps with some spasms of the muscles but I cannot recall.

Page 51

ln. 19 Q. Did you observe any stiffness in the thoracic region?

A. Well I have no-those records are not available to me, so I cannot comment.

Page 52

ln. 6 Q. In 1991 stiffness in the thoracic-how about limited motion in the lumbar 1991?

A. I have no specific information to that extent.

Q. And then going in 1996, do you have any specific recollection of stiffness in the thoracic on 12-5-96?

A. In 1996, there was no mention either in the history nor in my exam on the record that is available in front of me to that extent.

Q. And finally limited motion in the lumbar spine?

A. In the 1996 record? (12-5-96)

Q. Yes

A. I would have the same comment. There is no description of that either in the history nor in the examination.

Page 55

ln. 9 Q. What was the path of the pulling? (tension in head)

A. The only pulling that we have recorded was in the history what you described as pulling of the facial muscles.

Page 61

ln. 8 Q. Dr.Mancall, on this Thomas Jefferson Encounter form there is a notation about Crohns disease. Did you make any inquiry as to the patient's experience with the Crohns disease?

A. I have no record of that historically on that date.

Page 79

ln. 19 Q. This is an entry made by the acupuncturist. It's an entry of July 1996, chief complaint, pain and stiffness, neck,shoulders and upper back. Would you agree with that assessment as to anything you detected in the 12-5-96 exam?

A. No We received this information not in the history and no substantiation in the exam.

Signed 9-20-02 and noted by Court Reporter.pp. 1-95

University Counsel 2663959
Nov, 3, 1995 1454
Articles of Incorporation
Thomas Jefferson University Hospital, Inc.

First: The name of the corporation is Thomas Jefferson University Hospital, Inc.
Second: The location and post-office address of the initial registered office of the Corporation in this Commonwealth is 111 South 11th St., Phil., Pa. 19107. The Corporation may carry on its activities at several locations throughout the Commonwealth and surrounding area, and may change its principal business address from time to time as the Board of Trustees may determine.
THIRD: The Corporation is incorporated under the provisions of the Nonprofit Corp. Law of 1988.
(a) The Corporation is a nonprofit corporation organized for the following exclusively charitable, scientific and educational purposes within the meaning of 501(c)(3) of the Internal Revenue Code of 1986 as amended or the corresponding provision of any future United States internal revenue law: To own, lease or otherwise hold, manage or operate healthscare facilities and services; including

but not limited to the hospital assets and operations previously owned by Thomas Jefferson University (the "University"); to engage in patient care, education and research in conjunction with the charitable, scientific and educational activities of the University, the University's Jefferson Medical College (the "College"), Jefferson Faculty Foundation ("JEFF") , Jefferson Health System , Inc., (The "System") or others to participate in the organization and development of an integrated non-profit health care delivery system in conjunction with the university, the College, JEFF, the System or others to promote community health and well-being through clinical and statistical research and diseased prevention and treatment; to participate in the education and training of medical students, medical post-graduate students, practicing physicians and other heath care providers through relationships with the University, the college and other academic institutions and teaching hospitals; to develop through experimentation and study more efficient and cost effective systems and procedures for the delivery of health care services to the community and especially to medically underserved populations, and to engage in any lawful act or activities related to the foregoing consistent with the provisions of Section 501 (c)(3)

Sections FOUR TO THIRTEEN OMITTED

Paul C. Brucker MD

Thomas J.Lewis MD

IN THE UNITED STATES DISTRICT COURT FOR
EASTERN DISTRICT OF PENNSYLVANIA
JOSEPH S. MARESCA CIVIL ACTION
v.
ELLIOT L. MANCALL, MD, et al. NO. 01-5355
Philadelphia , Pennsylvania
May 5, 2004
BEFORE: HONORABLE LEGROME D. DAVIS, JR.
VIDEOGRAPHY AND TRIAL TRANSCRIPT
PLAYED IN COURT BEFORE HON. JUDGE DAVIS
ON 5-4-04

TRIAL EXAMINATION OF DR. JOHN R WATERMAN
MD- RHEUMATOLOGIST

APPEARANCES:
FOR PLAINTIFF: JOSEPH S. MARESCA, PRO-SE
BOX 646 BRONXVILLE, NY 10708

FOR DR.MANCALL: BRADLEY GOEWERT,ESQ.
1845 WALNUT ST.
PHIL. PA. 19103

FOR THOMAS JEFFERSON UNIVERSITY HOSPITAL: DOROTHY DUFFY, ESQ.
O'BRIEN AND RYAN
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2250 HICKORY ROAD
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PLYMOUTH MEETING
PA. 19462-1065

COURTROOM DEPUTY: MARCELLA EL SHABAZZ

PROCEEDINGS RECORDED BY ELECTRONIC SOUND
RECORDING OF KEVIN ASPINWALT OF
HAMILTON COMMUNICATIONS

TRANSCRIPT BY P: TINA DAVIS-BRANDON
REPORTING SERVICE, HARTFORD CONN.

EXHIBITS MARKED FOR EVIDENCE AND ENTERED AT TRIAL

91 Evaluation 9-8-99 pg. 42 Trial Transcript
92 Evaluation 9-8-99 p. 2
93 Patient Encounter Visit Note
94- 95 Letter from Dr.Waterman MD to Dr.Kellman MD pg. 43
96 Central Imaging Associates Medical Exam X-rays 9/99 pg. 43

DIRECT EXAMINATION
BY. MR. MARESCA (PLAINTIFF)

Page 8
ln. 8. Q. State your full name for the record.
ln. 9 A. John R. Waterman
ln. 10 Q. And your address
ln. 11 A. The Newington Campus of the
Veteran's Administration , CONN.
555 Willard Av. Newington, CONN. 6111
ln. 14 Q. Dr. Waterman, could you please provide us with
the year you graduated medical school.
A. University of Vermont 1972
ln. 21 Q. Do you have a specialization beyond general med?
ln. 23 A. Yes.
ln. 24 Q. What is that specialization
ln. 25 A. Rheumatology and internal medicine
Page 9-10

ln. 1 Q. Okay. Did you do your intership in rheumatology
at Johns Hopkins University in Baltimore, MD?
ln. 3 A. Well, technically it's a fellowship. Yes
ln. 12 Q. Have you handled ankylosing spondylitis patients?
A. Yes
Q. Approximately how many of them?
A. Oh. 50-100 maybe.
ln. 17 Q. Dr. Waterman, could you please go through what
you did on 9-8-99 with respect to the examination
of the plaintiff at UCONN.

ln. 21 A. Well, the plaintiff was seen by-initially a medical resident-his name I don't have and was evaluated with a history, physical exam, review of systems, past medical history, medication review, allergy review. And the patient was presented to me as the attending physician.

I then went into the office and clarified a few points in the history, family history, social history etc. And then we discussed our thoughts with the plaintiff. And the result of that was-I would want the plaintiff to get some x-rays, radiographs, which he did. He got them at Central Imaging Associates 1234 Central Park Av in Yonkers, NY

Page 11

ln.4 Q. Dr. Waterman, did you do a Schober test during your visit?

A. Yes, I did.

Q. And what were your findings?

A. Well, the Schober test was abnormal. But I can't give the exact measurements, because the resident did't dictate them in the notes. The normal Schober test is from 10-15 sonometers, so it was something less than that.

Q. Was the Schober less than 5 sonometers?

A. It was less than--it would be less on five sonometers, right. That would be an abnormal Schober.

Page 11-12

ln. 17 Q. Dr. Waterman, could you explain basically to a layperson what a Schober test measures?

A. It's simply a measure of lumbosacral flexion. The measures go from what's called the dimples of Venus, which is L-5, S-1, measure up to 10 sonometers, make a mark, have the patient bend over and try and touch his toes, and the distance that the mark moves is measured in sonometers. So ten, then if it's 5, it would be ten over fifteen, if it's two-it would be 10 over 12. It depends.

ln. 4 A normal Schober's is usually 5 sonometers or greater.

Q. For less than 5 sonometers, what period of time might it take for that patient to get to that stage? Is that something that happens overnight?

A. No, I don't think that happens overnight.

Page 14

ln.1 Q. What caused you to order an x-ray exam of the back?

A. It's usually standard operating procedure when you're dealing with people that complain of back pain to at least get a plain x-ray of the back. So I do it for most patients.

ln. 8 Q. Would part of that rationale be a suspicion of an inflammatory condition?

A. Possibly.

Q. Dr.Waterman, did you write this memo to Dr. Kellman MD in NY which is dated 9-15-1999?

A. Yes

ln.20 Q. Dr. Waterman, if you would very briefly describe why you prescribed Indocin and sulfasalazine, what those medications are intended to accomplish or their substantial equivalent?

A. They're standard-at that--1999, anyway, they were standard medications for the treatment of inflammatory back disease.

Q. So it's your testimony that the purpose of those medications is to deal with an inflammatory process in the back.

A. That is correct.

Q. Also, Dr.Waterman, would you confirm that this spondylitis may be secondary to the inflammatory bowel disease.

A. That is correct.

Page 16-17

BY MR.MARESCA

ln. 13 Q. Dr. Waterman, you mentioned here that the x-rays are compatible with the diagnosis of ankylosing spondylitis?

A. That is correct.

Q. Would it be fair to say that you communicated that to the patient on 9-15-1999? Is that a fair measurement date?

A. As far as I can tell.

ln. 24 Q. OK, you mentioned in this letter, "Those x-rays revealed that he has indeed a spondylarthropathy, which I had suspected." What caused you to suspect a spondylarthropathy?

A. Just some of the general physical findings.

Page 19

ln. 11 Q. Dr. Waterman, you took a regular x-ray or roentgenogram of the back. What will that show?

A. It showed changes of degenerative joint disease, it showed changes that were compatible with ankylosing spondylitis.

Q. Did it show specifically the bony structures and abornalities of the bony structures?

A. Well yeah, that's what an x-ray usually does.

Q. Dr. Waterman, when you examined the patient on 9-8-99 did you ever consider or was it in the medical history that the patient had an inter-ventricular tumor?

A. There's nothing here that even suggests that we asked that question.

Page 20

ln. 6 Q. Dr. Waterman, in considering a plethora of medications, did you ever consider Fiorinal?

A. No.

ln. 20 Q. Dr. Waterman, in examining the patient did you turn the head from left to right?

A. Yes

Q. Did you find a normal range of motion?

A. No. As I mentioned earlier, there was decreased cervical range of motion in all directions.

Page 21

ln. 1 Q. And at the point of making that finding what did you suspect?

A. That the patient had some sort of cervical spine disease.

Q. Is that a realistic suspicion on the part of the physician?

A. Absolutely.

Q. Did you move the patient's head up and down.

A. Yes. As I said, he had decreased cervical range of motion in all directions, so up, down, sideways, right , left.

ln. 13 Q. When you moved the neck from right to left, did you meet with any resistance?

A. All I can tell you is what is written down here. As I said before, decreased range of motion in all directions. So when you move the neck -it only goes so far and then it stops.

Page 24 Q. Nutrition question on ankylosing spondylitis

A. Outside of a balanced diet, there's no nutritional treatment of ankylosing spondylitis I'm aware of.

Page 34 Cross Examination Excerpt of Bradley Goewert,Esq

ln. 22 Q. Now, in your examination of him-you examined his neck and back because he had had some complaints of neck and back stiffness, right?

A. That is correct.

REDIRECT EXAMINATION

Page 41

ln. 6 Q. Dr.Waterman, you've indicated to Dr.Kellman in your memorandum, "Mr.Maresca's a gentleman with a great deal of musculoskeletal complaints" What does that mean generally? Could you expound upon that?

A. What does it mean to me? It just means that you conveyed a lot of achiness.

Page 42

ln. 4 Q. The last item, Dr.Waterman, do you waive the signing and allow the transcript to be presented to the Court as is.

A. Fine with me.

VIDEOGRAPHER-That concludes this testimony. Going off the record at 5:38 PM.

PLAINTIFF'S EXHIBITS 91-96 marked for identification.

Analysis: Dr. Waterman MD-Rheumatologist attests to a bone disease, gross range of motion problems, the need for an anti-inflammatory protocol and the fact that an interventricular tumor was never considered. P.63 "There's nothing here that even suggests that we asked that question. " This is significant because Dr.Mancall's hypothesis was an interventricular tumor. For this, he took an expensive MRI of the brain which showed cerebellar atrophy . There's nothing in the record indicating any followup of the cerebellar atrophy by Dr.Mancall MD. There are 3 classic cerebellar atrophies in medicine. These are Olivopontocerebellar Atrophy, Parenchymatous Atrophy of the Cerebellum and Primary Degeneration of the Corpus Callosum (Marchiafava's Disease of the Mediterranean peoples).. Nowhere in Dr.Mancall's record is there any notation of his analysis of the type of cerebellar atrophy found. A.50; A.118; A.119 & A.122

Trial Exhibit 93-Approved by Court

University of Connecticut Health Center
Farmington CT. 06030

PATIENT ENCOUNTER VISIT NOT TEACHING
PHYSICIANS CONTINUED PROGRESS NOTE

HPI: Neck stiffness
PE: & C spine & schober

DX: probable cervical & lumbar spondylosis

PLAN: L/S & C spine

John R. Waterman MD--Teaching Physician's Signature

Trial Exhibit 94 Admitted by Court
UCONN MEDICAL GROUP
RHEUMATOLOGY ASSOCIATES
September 15, 1999
Dr.Raphael Kellman
124 East 36th St, NY 10016

RE: Joseph S. Maresca
MRN 881837

Initialled by Dr. Kellman MD 9-28-99

Dear Dr.Kellman,
I had the opportunity of seeing Mr.Maresca at UCONN Division
of the Rheumatology Clinic on 9-8-1999. As you know, Mr.Maresca is a gentleman with a great deal of musculoskeletal complaints. In addition, he has a history of inflammatory bowel disease.. When he came to see me, the only information available to me was his own notes regarding various types of procedures and analyses that had been performed on him. My understanding is that you have training in both internal medicine and holistic.

After my examination, it was evident that Mr.Maresca had marked decreased range of motion of his axial skeleton. Consequently, I obtained some radiographs performed at Central Imaging Associates on 1234 Central Park Av. Yonkers NY . Those x-rays revealed that he does, indeed have a spondylarthropathy, which I suspected. His x-rays are compatible with a diagnosis of ankylosing spondylitis. In addition, this type of spondylitis may be secondary to the aforementioned history of inflammatory bowel disease.

I spoke with Mr.Maresca today (9-15-99). I told him that he would probably benefit from either a nonsteroidal anti-inflammatory (Indocin) or sulfasalazine. He has been on sulfasalazine in the past for his inflammatory bowel disease and actually tolerated it quite well. I instructed him to get in touch with you since he regards you as his primary care physician. I feel uncomfortable prescribing medications like this from such a long distance. It would be impractical for him to come to the UCONN in Farmington, CONN., on a regular basis for monitoring of these medications. I also mentioned the fact that he could, perhaps, be referred to a local rheumatologist who then could monitor his care.

The dose of indomethacin that is usually used for spondylarthropathy is 50 mg t.i.d. Sulfasalazine is given in a total dose of approximately 2-3 grams per day, usually in divided does (b.i.d.) Both those medications have been shown to
be effective in the treatment of inflammatory back pain.
Sincerely,
John R. Waterman, MD-Assistant Professor of Medicine
Dictated by John R. Waterman MD
TRID 9909152232513504O0 DP 9-171999 12:05DD
9-15-99 18:37 DT 9-17-1999 11:55 TID 10982

Trial Exhibit 96-Approved by the Court

Central Imaging Associates

9-9-1999
RE: Maresca, Joseph S.
D/Exam 9-9-1999

John R. Waterman MD
263 Farmington Rd
Farmington CT 06030 DOB 1-14-1952

CERVICAL SPINE WITH OBLIQUE VIEWS:

AP, lateral and both oblique views were obtained.
There is evidence of ossification of the anterior longitudinal ligament with bridging syndesmophytes noted. There is no foraminal stenosis. Disc height is preserved. There is suggestion
of multilevel facet fusion. No prevertebral soft tissue abnormality
is noted. The C2-C2 articulation is normal.
IMPRESSION:
Ossification of the anterior longitudinal ligament and findings
consistent with multilevel facet fusion. Differential diagnosis for these findings including ankylosing spondylitis as well as other seronegative spondylarthropathies.

Trial Exhibit 96 - continued

LUMBOSACRAL SPINE:
AP, lateral and a coned down lateral view of L-5-S1 were obtained. There is ossification of the anterior longitudinal ligament
with evidence of extensive syndesmophyte formation at multiple
levels. There is preservation of disc height except at L4-L5 and L5-S1 when there is mild disc space narrowing noted. There is multilevel facet overgrowth and calcifications of the infraspinous ligaments. Alignment is within normal limits. There is fusion of the sacroiliac joints. No periarticular erosions
are seen. The symphysis pubis is intact.
IMPRESSION: Multilevel syndesmophytes with ossification of the anterior longitudinal ligament.

IN THE UNITED STATES DISTRICT COURT FOR
EASTERN DISTRICT OF PENNSYLVANIA
JOSEPH S. MARESCA CIVIL ACTION
v.
ELLIOT L. MANCALL, MD, et al. NO. 01-5355
Philadelphia , Pennsylvania
May 5, 2004
BEFORE: HONORABLE LEGROME D. DAVIS, JR.
VIDEOGRAPHY AND TRIAL TRANSCRIPT
PLAYED IN COURT BEFORE HON. JUDGE DAVIS
ON 5-4-2004

TRIAL EXAMINATION BY VIDEO OF:
CREATED: MARCH 30, 2004 begins 11:04AM-11:27AM
DR.RAPHAEL KELLMAN, MD-INTERNIST
124 EAST 36TH STREET, NY

APPEARANCES:
FOR PLAINTIFF: JOSEPH S. MARESCA, PRO-SE
BOX 646 BRONXVILLE, NY 10708

FOR DR.MANCALL: BRADLEY GOEWERT,ESQ.
1845 WALNUT ST.
PHIL. PA. 19103

FOR THOMAS JEFFERSON UNIVERSITY HOSPITAL: DOROTHY DUFFY, ESQ.
O'BRIEN AND RYAN
HICKORY POINTE
2250 HICKORY ROAD
SUITE 300
PLYMOUTH MEETING
PA. 19462-1065

COURTROOM DEPUTY: MARCELLA EL SHABAZZ
PROCEEDINGS RECORDED BY EDWARD FORD
CERTIFIED LEGAL VIDEO SPECIALIST
TRANSCRIPT BY :SANDRA NOEL BARTELS-COURT
REPORTER- AND NOTARY PUBLIC.

EXHIBITS MARKED FOR EVIDENCE AND ENTERED AT TRIAL

Exhibit 69 Letter, page 1 of 2, 9-15-99
Exhibit 70 Letter page 2 of 2 9-15-99
[Letter from Dr.Waterman MD-Rheumatologist to Dr.Kellman MD-Internist and treating physician outlining the diagnosis of ankylosing spondylitis and inflammatory treatment
Exhibit 71 Glycemic Challenge Profile
Exhibit 72 Lab 2-14-2000
Exhibit 73 Lab 5-21-99
Exhibit 74 Encounter form 5-11-99
Exhibits 75, 76 Web documents
Exhibit 77 Invoice 4-28-2000
Exhibit 78 Invoice 9-24-99
Exhibit 79 Invoice dated 9-24-99
Exhibit 80 Invoice dated 10-21-99
Exhibit 81 Invoice dated 11-17-99
Exhibit 82 Lab 2-10-2000
Exhibit 83 Invoice dated 3-30-2000
Exhibit 84 Invoice dated 4-4-2000
Exhibit 85 Invoice dated 4-13-2000
Exhibit 86 Invoice dated 5-30-2000
Exhibit 87 Invoice dated 6-22-2000
Exhibit 88 Invoice dated 3-29-2000
Exhibit 89 Lab report dated 5-21-99
Exhibit 90 Lab, collection date 4-15-98

RAPHAEL KELLMAN MD, called as a witness having been duly sworn by a Notary Public, was examined and testified as follows:

Page 6

Ln 7 Q. Dr. Kellman, please state your full name & address for the record. (Questioning by Plaintiff-Maresca-Pro-se- Appellant)

A. Dr.Kellman MD at 124 East 36th St. NY 10016.

Q. Dr.Kellman, are you a graduate of Einstein Medical School?

A. Yes

Q. And you specialize in internal medicine.

A. Yes

Q. Dr.Kellman, if you would look at Exh. 69, a letter dated September 15, 1999 to you.

A. Yes

Q. From Dr. John R Waterman MD.

A. Correct.

Q. Have you read this letter?

A. Yes

Page 7

ln. 7 Q. Dr. Waterman is mentioning a diagnosis here of ankylosing spondylitis. Do you concur with that diagnosis?

A. I could just tell you what he said. You know, I'm not a rheumatologist to make such an extensive diagnosis

Q. Well, he is recommending treatment--

A. Well , based on his premise, then his treatment would make sense. Again, I'm not a rheumatologist to make these types of diagnoses.

Page 7-continued

ln.20 Q. He's recommending an anti-inflammatory, indomethacin and sulfasalazine. What do these medicines accomplish?

A. They reduce inflammation.

Q. And in your practice, did you prescribe that for the patient or did you prescribe something of another nature?

A. Well my approach is more natural and I would use natural anti-inflammatory agents, agents that improve a deeper underlying cause.

Q. Which anti-inflammatory agents did you choose? Okay, I have exhibits here. Let's see if we can go to Exhibit 77 first. This is showing a description of Intestamine. What would Intestamine accomplish?

A. That would reduce--that would improve gastrointestinal function, specifically the gastrointestinal wall, the function of the cells of the gastrointestinal wall so that there would be less inflammation and less permeability to potential toxins and agents that can evoke the immune system to create an inflammatory state.

Q. Okay. Also, I'm showing on Exhibit 83, you're using Vitamin C and Magnesium drips.

A. Yes,

Q. What will that accomplish?

A. Well Vitamin C does many things.

Page 9

ln.4 A. It improves the immune (system). It can also be an anti-oxidant in low doses which can then improve free radical development. Magnesium also has many functions. It can improve cardiac function. It can improve muscle function.

Q. Also, Dr.Kellman, with respect to the treatment modalities that would be helpful for musculo-skeletal complaints that Dr. Waterman is mentioning on Exh. 69, would you recommend acupuncture, would that be helpful?

ln.22 A. My belief is that acupuncture can help many conditions in a general way in that it improves the ecology of the body.

Page 10-11

ln. 17 Q. Dr. Kellman, did you perform this glycemic challenge profile in Exhibit 71?

A. Yes.

Q. What did that show?

A. It shows that you have a very high glucose level and a high insulin level and it is consistent with diabetes.

Q. How did you treat that?

ln. 25 A. Well, we recommended a drug called Avandia, weight loss, dietary intervention, exercise, mild exercise and a few supplements that also improve glucose control.

Page 11-12

ln. 5 Q. Okay, Dr.Kellman, did you see this Exh. 73, yeast profile?

A. Yes.

Q. Do you believe that yeast was important to-- or the elimination of yeast would have been helpful in my program of treatment?

A. Well, you know , that's a controversial issue. I think there is evidence for the notion that there is a connection between yeast, Candida, and byproducts of Candida, and various physiological abnormalities. And therefore, the control of yeast overgrowth can help improve various abnormal physiological states.

Page 12

ln. 12 Q. I would like to get very quickly back to Exh. 69 and here Dr.Waterman is mentioning to you X-rays compatible with ankylosing spondylitis.
Is this 9-15-1999, the first date or the earliest date that the process ankylosing spondylitis was ever mentioned to you or discussed with the patient; is this a fair date (for measurement purposes)?

A. Yes.

Page 15

ln. 11 Q. Did any of your treatments deal specifically with inflammation?

A. Yes. The use of intestamine, Vitamin C. I don't remember offhand the other supplements that we gave, but the control of glucose and insulin, hyperinsulemia, high levels of insulin, in and of itself reduces inflammation.

Page 18- Cross Examination Excerpts of Mr.Goewert,Esq.

ln. 14 Q. Now, Dr.Waterman was a rheumatologist who saw Mr.Maresca in September 1999 and he had recommended a non-steroidal anti-inflammatory, indomethacin and sulfasalazine. Now do you prescribe those types of medications in your practice?

A. Infrequently.

Page 19 On re-direct by Maresca- Pro-se Plaintiff

ln. 24 Q. On redirect, just one item to complete. The hair analysis you would have completed on 4-29-1998. Is that a fair date?

A. Yes

Q. So that at least by that time you would have been seeing me.

A. Correct

THE VIDEOGRAPHER: The time is 11:27 AM on 3-30-04 This is the end of Tape 1 and this completes the videotape of Dr. Kellman MD-Trial Exam.

Trial Exam Exhibits 69-70 are a 9-15-1999 letter from Dr. Waterman MD-Rheumatologist to Dr. Kellman MD advising him of the ankylosing spondylitis finding and the treatment protocol of indomethicin and sulfasalizine for internal inflammations. This letter is in the Trial Exam of Dr. Waterman.

Exhibit 71, 72-Approved by the Court

Glycemic Challenge Test by Diagnos Techs Inc.
Clinical and research Lab
Third Quarter 1999
Severe Pre-diabetic state
Insulin Resistance
Recommend: Glycemic dietary control
Avandia 4 mg. / day
Biogymnematid

Trial Exhibit 72- Approved by Court

KCPM Labs
124 E. 36th St.. NY 10016
212-532-0600
Raphael Kellman MD, Lab Director
Name: Maresca, Joseph S. 011452 Sex M
Phone: 914-649-3817
Drawn : 2-10-00

General Chemistry: Glucose 121 Ref. Range 65-125

Trial Exhibit 73 -Approved by Court

Microscopic Oxidative Stress Test (MOST)
(HighResolution Phase Contrast, Dark Field and Light Microscopy of Peripheral Blood Smears Blood Yeast and Microbial Assessment on TV Screen)

D-Decreased PLF-anaerobic microbes

Maresca, Joseph S. 5/ 21/ 1999

Rouleau	+1
RBC Crenation Spikes	+1
RBC Membrane Damage	+1
RBC Lysis	+1
Lymphocytes I/D/N	D
Lymphoblasts	+3
Platelets	D
PLF'S Pale	+4
PLF'S dark	+4
PLF-Hyphae Black & Wh	+2
Yeast Pattern	+4
Viral Pattern Chronic	+1
Oxidative Coag	+4
AA Oxidopathy	
Total Stress	+4
Crystals and Misc.	+2

Pathologist: Dr.Magid Ali MD
140 West End Av. Suite 1H NY NY 10023

Trial Exhibits 77-89 Under Advisement by Court
in the Appellate Record
Dr.Kellman's Treatments
for Inflammation

Exh. 77 Intestamine and IM Injection 4-28-2000

Exh 78 Blood Chemistry Metabolic Panel,
CBC,Lipid,VLDL,
Creatinine, Prostate , TSH , T-3, T-4, Free T4,T
uptake
H-Pylori and APO Lipoprotein $380. 9-24-99

Exh 79 Vitamin Infusions and Extended Office Visit
9-24-99
$190

Exh. 80 Glucose and Insulin Tolerance Office Visit $837.

Exh 81 Intestamine 360 GM and Office Visit $90.

Exh. 82 Glucose General Chemistry at 121 level 2-14-2000

Exh 83 IV Drip vitamins and Magnesium $30 3-30-2000

Exh. 84 Vit C and Magnesium drips $30. 4-04-2000

Exh. 85 Vit C and Mag. Drips $30.4-13-2000 4-13-2000

Exh 86 Vitamin Drips $30. 5-30-2000

Exh. 87 IM Injections, Ultra Fiber $30 6-22-2000

Exh. 88 Colonic hydrotherapy 6 visits $500. 3-29-2000

Exh. 89 Smithkline Beecham Clinical Labs 5-21-1998-Stool
Concentrate Result-No Parasites Seen
Trichrome Result- No Parasites Seen

Exh. 300 Great Smokies Diagnostic Lab-Hair Analysis 4-21-
98
Toxicities Found: Lead 3.46; Magnesium 16.18 on
a 30-70 Ref. Zinc at 105 s/b 110-163;
Cobalt .005 s/b .01 ; Iodine 0 s/b .11
Stronium .2 and s/b .25; Ca. 210 s/b 215-780

IN THE UNITED STATES DISTRICT COURT FOR
EASTERN DISTRICT OF PENNSYLVANIA
JOSEPH S. MARESCA CIVIL ACTION
v.
ELLIOT L. MANCALL, MD, et al. NO. 01-5355
Philadelphia , Pennsylvania
May 5, 2004

BEFORE: HONORABLE LEGROME D. DAVIS, JR.
VIDEOGRAPHY AND TRIAL TRANSCRIPT
PLAYED IN COURT BEFORE HON. JUDGE DAVIS
ON 5-5-04 AND 5-6-04

TRIAL EXAMINATION OF DR. MITCHELL FELDER MD
NEUROLOGIST-EXPERT WITNESS

APPEARANCES:
FOR PLAINTIFF: JOSEPH S. MARESCA, PRO-SE
BOX 646 BRONXVILLE, NY 10708

FOR DR.MANCALL: BRADLEY GOEWERT,ESQ.
1845 WALNUT ST.
PHIL. PA. 19103

FOR THOMAS JEFFERSON UNIVERSITY HOSPITAL: DOROTHY DUFFY, ESQ.
O'BRIEN AND RYAN
HICKORY POINTE
2250 HICKORY ROAD
SUITE 300
PLYMOUTH MEETING
PA. 19462-1065

COURTROOM DEPUTY: MARCELLA EL SHABAZZ
TRANSCRIPT: TINA DAVIS-BRANDON REPORTING
PROCEEDINGS RECORDED BY ELECTRONIC SOUND
RECORDING OF KEVIN ASPINWALT OF
HAMILTON COMMUNICATIONS

Swearing in of the expert witness by Ms. Moore-Notary & Transcriptionist

Page 6 Direct Examination by the Plaintiff

ln. 5 Q. By Mr. Maresca (Plaintiff)
Would you state your full name and address.

A. My name is Mitchell S. Felder, MD. I'm at Suite 2 87 Stambaugh Av., Sharon Penn. 16146.

Q. And Diplomate Felder, which medical school did you attend.

A. I a graduated from the University of Rome Faculty of Medicine.

Q. And what year was that ?

A. 1983

Page 7

ln. 1 Q. Also, when did you get a designation as Diplomate?

A. Well, I passed two Board exams. One was the American Academy of Clinical Neurology, Dec.'90. I'm Board Certified in Neurology by the American Board of Psychiatry and Neurology in April 2000.

Q. If you could explain briefly what is a Diplomate and what additional training is involved?

A. Well, I had to-I was an intern qualified for neurology. I then did-I was a resident in neurology at St.Vincent's Hospital in Manhattan. I was chosen to be the Chief Resident in Neurology. After that, one takes a Board exam, which is a multi-faceted exam, both written and oral, which shows competency in the subject of neurology.

Page 7

Ln. 17 Q. How much does a-does a Diplomate distinguish from a person-just a regular neurologist in your view?

A. I would think a knowledge of and competency in the field of neurology.

Page 8

ln.1 Q. Okay, if you could quickly go over the hospitals you've worked for?

A. Of course, I was at Englewood Hospital, in Englewood, NJ as an intern. I was then a neurology resident at St.Vincent's in Manhattan. I then came to this area, Sharon Regional Health Systems, which was called Sharon General Hospital. And since the last 5 years, I've been at UPMC Horizon Campus, University of Pittsburgh Medical Center.

Q. Have you handled many hospital records in your experience?

A. Yeah, definitely.

Q. Encounter forms and patient records, things of that nature?

A. Yes, I have

Q. Are you comfortable with what an acceptable standard in the preparation of a record should be from your experience in working in hospitals?

A. Yes

Q. Okay, if you could go over your experience as a disability examiner.

Page 9

ln. 1 A. I've been a disability examiner for the Social Security Disability part of the government, of course and that's been since 1990 to the present. That's involved in examining patients, writing a report. I don't decide specifically what is their disability from the Social Security Disability Office, but then I write a report that the Social Security Disability Examiner Office decides whether or not to classify the person as disabled.

Q. Have you handled cases of the spine?

A. Yes

ln. 12 Q. Have you handled cases involving cerebellar atrophy?

A. Yes

Q. Have you handled cases involving ataxias?

A. Yes.

ln.22 Q. Okay. With respect to the different spheres of the brain, you're comfortable in analyzing those?

A. Yes. That's again, part of generic neurology.

Page 10

ln. 7 Q. Also, Diplomate Felder, have you ever worked with an acupuncturist in your career?

A. Tangentially, I sent patients to see an acupuncturist from my office for chronic pain.

Q. Okay, and have you had a good experience in terms of your sending patients to acupuncturists?

A. Fairly good, yes.

Q. Are you comfortable in having an acupuncturist treat a person?

A. Yes, I am

Q. Do you believe that acupuncture has any scientific validity?

A. Yes, I do. I'm not exactly sure whether it increases endorphins or is affecting the nerve transmission & in what way, but I believe it does have some validity.

Q. Diplomate Felder, have you ever handled patients formerly in Europe, as well as the United States?

A. Yes

Page 12

Ln. 3 Q. Okay. All right. Diplomate Felder, if you would kindly get into the details of the work you performed in analyzing the various medical records and depositions put before you.

A. I reviewed the records, the deposition of Dr.Mancall, deposition of Mr. (Diplomate)Deng, and the deposition of Dr.John Waterman, which you can see right here. These are-this is what I reviewed.

Q. Okay. And in reviewing those depositions if you would refer to Diplomate Deng because that is his title.

A. Yeah. Diplomate Deng

My- after reviewing this, it was my conclusion that

ln. 18 A. the patient's head movements were not examined, nor was the -there to my knowledge reviewing these documents in my medical opinion, an examination of the spine.There was no recollection of the patient's position. There was deficiency of looking at neck posture. There was deficiency in not looking at neck posture. There was no evaluation of the pelvic area.

Page 13

ln.1 There was no exam to my knowledge of rotation of the thigh.

The patient, yourself , Mr.Maresca was given a diagnosis of chronic tension headaches at the time. I reviewed, of course, Dr.Mancall's testimony and this sheet here, which is the sheet from the Thomas Jefferson University Hospital physical exam. It's somewhat difficult to read, but you know, you see motor deep tendon reflexes.

ln. 12 Q. On 12-5-96, did Dr.Mancall make a correct diagnosis?

A. No. It is my medical opinion, that the correct diagnosis would have been ankylosing spondylitis.

Page 13 continued

ln. 17 Q. What causes you to have that opinion?

A. A number of problems. First of all, that there was an insidious onset of the condition as per Harrison's Principles of Internal Medicine, duration greater than three months, morning stiffness. There was some improvement with exercise or activity, from what I read in the record of the testimony. And the fact that of course that the correct diagnosis was achieved by Dr, Waterman at a later date.

Page 14

ln.1 Q. In your opinion, did Dr.Mancall take the correct test?

A. No. It's my medical opinion that the correct test wasn't performed at that point in time and that one possibility would be an MRI of the sacroiliac area. Something else would be-that could possibly be used is what's called HLA-B27, histocompatibility antigen. Of course, x-rays. As per Harrison's Textbook of Medicine, MRI has emerged as a specific technique for identifying intraarticular inflammation, cartilage changes in sacroilitis. This is what I know, reviewed in Harrison's Principles of Internal Medicine 15th Edition.

ln. 24 Q.Dr. Felder, in your opinion from reviewing Harrison's Textbook on Internal Medicine, do you believe that that book has scientific validity? And if so, why?

A. Without question, it's the major textbook in the United States for the study and practice of Internal Medicine. It's written by a plethora of top authorities, and it's hard to imagine a better text.

Page 16

ln. 1 Q. Diplomate Felder, I would like to get back to the testing. You indicated that Dr.Mancall took the MRI of the brain and that he should have taken the roentgenogram of the back, is that correct?

A.That's correct.

X-ray of the back, or better yet would have been MRI of the sacroiliac area.

Q. Now in taking the MRI of the brain, did Dr.Mancall document his analysis of the result of the MRI of brain?

Let me show you these two exhibits. Exhibit 44 is the order for the MRI of the brain, and Exh. 45 is the MRI of the brain.

A. Yeah, this is--

Q. Diplomate Felder, have you ever seen these exhibits?

A. Yes, I believe so.

Q. Okay.

A. And the impression of course is cerebellar atrophy.

Q. Now with a finding of cerebellar atrophy, do you see on the Thomas Jefferson University encounter form any evidence that Dr.Mancall came to a conclusion on whether or not the cerebellar atrophy was problematic?

A. I can't recall that he did come to that conclusion that it's problematic.

Page 17

ln. 16 Q. Dr.Felder, are you qualified to understand what cerebellar atrophy means?

A. Yes, it's atrophy of the cerebellum.

Page 18

ln. 12 Q. So would it be safe to say that you really-- you have no way of knowing what conclusion or what documented conclusion Dr.Mancall came to from looking at the face of the Thomas Jefferson University encounter form?

A. That is correct.

Page 19

ln. 3 Q Should that encounter form list his analysis of the MRI of the brain?

A. Yes. One--a physician can put the reference to a report of the brain -on an encounter form.

Q. Okay. Also, is there any evidence on the face of the form as to whether or not Dr.Mancall did a comprehensive analysis of gait?

A. No, I cannot find exactly a-I can't see the word gait on this form.

Q. In your opinion, would a comprehensive analysis of gait help in coming to a diagnosis of ankylosing spondylitis?

A. Yes, it could help.

Page 20

ln 1 A. It would indicate to a physician that there is a problem with ambulation with--and lead to possibly further testing. It's a classic part of a neurologic exam, a description of gait.

ln. 23 Q. And also, could you tell me whether or not the dorsal lobules displayed more severe atrophy than the lateral hemispheres.

A. I can't see that on the form.

Page 22

ln. 12 Q. Okay. Is there any indication on the face of the Thomas Jefferson University encounter form that Dr. Mancall monitored the use of Fiorinal, or in fact, if he knew that it was ever prescribed?

A. I can't specifically say that I see that.

Q. Should there be that kind of evidence or notation?

Page 23

ln. 1 A In my opinion, my medical opinion, I believe there should be a follow-up visit after a visit such as this. That's my opinion.

Q. Okay. There are three subsequent letters that the patient sent to Dr. Mancall and that he has admitted to reading. Have you reviewed those letters?

A. Yes. They're in here. That's part of the record here.

Page 24

ln. 18 A. It's my opinion that a patient-I'm sorry, a physician receiving a letter from a patient should respond to the patient in some form, written or oral. Your telephone number is on the letter.

Q. Is there any evidence on the face of the Thomas Jefferson University Hospital encounter form, which indicates that Dr.Mancall made any attempt to contact the patient?

Page 25

ln. 3 A. I don't know of such evidence.

Q. And if we could back track , a minute, you have testified ,Diplomate Felder, that Dr.Mancall should have done some followup with respect to the patient.

A. That's my opinion.

ln. 20

Q. Okay. Specifically, in your medical opinion, should there be a notation on the Thomas Jefferson University encounter form with regard to the letter of February 9, 1997?

Page 26

ln. 3 Q. This is exhibit 46

A. Exhibit 46, yeah. See this is covered up here. That's what's giving me a problem. Perhaps that's one thing, but typically physicians will call the patient and then write a note in the chart, making reference to the letter, which would also typically be in the chart.

Q. Did you-have-did you see any evidence of a notation of attempts to call the patient in the chart?

A. I don't recall seeing any of that.

Page 28

ln.7 Q. Diplomate Felder,have you seen this letter of 2-15-97 addressed to Dr.Mancall? Exhibit 47

A. It's a letter from you to Dr.Elliot Mancall, stating that they had-you-the two of you had discussed the MRI, showing cerebellar atrophy; that you had seen Dr.Filannino, who prescribed Imitrex at 25 milligrams to treat headaches; that you don't have tingling in the fingers; and that the tension in your upper pallate of the mouth has reduced significantly, but that you still have tension in the forehead, which worsens at night.

It goes on to say that you and Dr. Filannino had discussed increasing the dosage to 50 milligram pills and that this option might clear up the remainder of your headache and that you--we, referring to yourself and Dr.Filannino would have to try another medication or combination of medications. You then go on to ask if Dr.Filannino should do arteriography.

Page 29

And you later state that you'd like at least two physicians to examine the films in detail to come to the same or similar conclusions, and that you stated that you were concerned that the MRI has been taken and

ln.8 interpreted properly.

ln9. Q. Okay, upon reading this letter, what would your reaction be to that letter as a neurologist?

A. I would in my practice, most probably contact the patient and ask the patient to come in for a followup visit.

Q. Do you see any evidence on the face of the Thomas Jefferson University Hospital encounter form which accomplishes what you've just suggested?

A. No. I don't see any specific evidence of that.

Q. Should there be some sort of evidence of that, in your medical opinion?

A. Well, it's my opinion that receiving--having received letters, in general, a physician should respond to the letters and contact the patient and possibly have follow-up visits with the patient.

Page 30-1

ln. 3 Q. And I'm going to give you the final exhibit 48, which is a memo written also addressed to Dr.Mancall, the last memorandum of its kind, on 2-27-97 or that's what it looks like at the bottom.

A. Yeah

Q. If you could summarize what is in there?

A. Well again, you're saying that you saw Dr.Filannino He had increased the dosage of your medication, I would gather of Imitrex, which is sumatriptan to 50 milligrams a day, that you were not having permanent relief of the headache except at night when you were lying down. The Imitrex did appear to relieve the tingling in the fingers. However, the tightness of , as you put it, trigeminal nerve structures continued unabated. You then mentioned a use of Haldol or Robaxin or one of the muscle relaxants; that you have a personal acupuncture appliance which delivers measured electrical stimulation to the forehead; and that it is not a permanent solution. And then you finally conclude in the third paragraph, Kindly consider all of the above and advise me -as to which direction might provide me a permanent resolution of this headache. Signed by yourself, with your telephone number.

Q. In your medical opinion, what should Dr.Mancall have done upon receiving this letter?

A. It would be my opinion that a physician receiving a letter from a patient of this nature should call the patient and/or schedule a follow-up visit.

Q. Do you see any evidence on the face of the Thomas Jefferson University encounter form that that was done?

A. No I don't.

Q. Or even attempted?

A. No, I don't see an indication specifically of that.

Page 32

ln. 11 Q. Okay. Dr.Felder, I'm giving you Exhibit 49, which is a memo prepared by myself and taken to the 12-5-96 encounter with Dr.Mancall to which he has admitted receiving and reading in his deposition . OK this letter mentions the permanent restriction in the ability to do sit-ups or to run at maximum speed.

A. That is correct.

Q. Diplomate Felder, in your opinion given this type of complaint, what would you do?

A. In my opinion, I would follow up with a patient until there was a specific diagnosis of their condition and/or they were having some improvement in their condition.

Page 33

ln. 1 Q. Specifically, is there a diagnostic test you would take to evaluate that complaint?

A. Well, certainly x-rays of the back. Again one could consider MRI of the sacroiliac region as per Harrison's Principles of Internal Medicine.

Q. Do you see any evidence on the face of the Thomas Jefferson University encounter form that indicates that Dr.Mancall considered any of those things?

A. I don't see such a thing.

Q. And also, if you could repeat the diagnostic test that you think should have been taken?

A. An MRI of the sacroiliac area, x-rays of the lumbo-sacral area, blood tests for HLA-B27 could have possibly been taken.

ln. 20 Q. And, Diplomate Felder, in taking those specific tests do you believe that any one of those would have lead to the discovery of ankylosing spondylitis?

A. It's my opinion that, yes that would have given a strong indication.

Page 34

ln. 1 Q. And could you attach the likelihood that it would have given a strong indication of ankylosing spondylitis?

A. In my opinion, within a reasonable degree of medical certainty, it would have given that in my opinion.

Q. Okay, Also in your medical opinion, did Dr. Mancall ever analyze the path of the tension headache or the spinal root distribution?

A. I don't recall that being done.

Page 35

ln. 8 Q. Okay. Diplomate Felder, do you see any evidence on the face of the Thomas Jefferson University encounter form that Dr.Mancall ever attempted to contact the successor physician in this case Dr. Filannino?

A. I do not recall such a statement.

Q. Is there anything on the face. [of the encounter form?

A. Such a record, no, I don't remember seeing that.

Q. Diplomate Felder, do you believe that it would have been important for him to communicate with the successor physician?

A. Yeah

Page 36

ln.8 Q. -if you could put in front of you, the record of the rheumatologist-Dr.Waterman?

A. The deposition of Dr.Waterman?

Q. Yes, both the deposition, as well as Dr. Waterman's encounter form and his letter to Dr. Kellman.

Page 37

Q. This is Dr.Waterman's roentgenogram of the back-taken in September 1999.

A. Well, you have a cervical spine with oblique views, with a the impression of ossification of the anterior longitudinal ligament, findings consistent with multi level facet fusion.

A differential diagnosis for these findings would include ankylosing spondylitis, as well as other seronegative spondylarthropathies. There's also a lumbosacral spine showing ossification of the anterior longitudinal ligament, mild disk space narrowing, overgrowth in calcifications, fusion of the sacroiliac joints. What's-that's basically it.

ln. 19. Q Okay. If you could review for us what is an ossification?

A. It's a bony--a formation--increased bone formation, like from the word ossify.

Q. And what are the implications of that for the patient.

A. Could be chronic inflammation, increased calcium formation.

Page 38

ln.10 Q. There's a suggestion of multi-level face fusion. What is that?

A. That's different levels where the facets of the vertebrae are fusing , are coming together tightly.

Q. And the impression, it says differential diagnosis of ankylosing spondylitis and other seronegative spondylarthropathies ?

ln. 20 A. Well, that's indicative that the ankylosing spondylitis is the differential diagnosis.

Page 39

ln. 1 Q. And in the lumbosacral spine, it has again ossification of the anterior longitudinal ligament, with evidence of extensive syndesmophyte formation at multiple levels.

What does that mean to a lay person?

A. Again, there is inflammation and chronic-there's chronic inflammation with a decrease in intertissue space.

Q. Underneath, it says there is a multi-level facet overgrowth and calcifications of the infraspinous ligaments. What does that mean to a layperson?

A. There's more calcium there than one would expect.

Q. And then going further down, there is fusion of the sacroiliac joints. What would that mean to a layperson?

A. The sacrum and the ilium are fused. They've been brought together.

Page 41

ln.1 Q. Diplomate Felder, did you read Diplomate Deng's Deposition?

A. Yes, I did.

Q. Completely?

A. Yes, I read it.

Q. The Aug. 20, 2002 deposition [filed with the D.C.]

A. Yeah. Telephonic deposition of Diplomate Charles Deng.

Q. And in reading the deposition, did you rely upon the deposition in formulating your opinion as to the existence of ankylosing spondylitis as of 12-5-96?

A. I believe yes, that was an element in coming to that conclusion.

Q. How much of an element would it have been?

A. It's hard to say. I'd say some element, 20 , 30%, I really don't know. It was a compilation of materials.

Q. Okay. With your permission, I'd like to just read some of what Diplomate Deng testified to on 8-20-02.

Counsel Objection

MR.MARESCA. Okay. But I will advise the Court that Diplomate Felder has indicated that he has considered Diplomate Deng's deposition in coming to his conclusion and so I think that it will lead to material helpful to the Court.

Page 42 Plaintiff deposing Diplomate Deng on 8-20-02

ln. 4 Q. Okay, On Page 13, starting on Line 3- and this is a quotation, and I'm going to read approximately a 1 1/2 pages.

Q. Okay, In your observation (Diplomate Deng), did you observe stiffness in the first meeting and subsequent meetings? Back on 7-6-1996, was there stiffness.

A. Answer on ln. 7, I did not catch your question exactly.

ln.9 Q. Yes. When you examined the patient

A. Yes

Q. Did you find stiffness particularly stiffness of the head, stiffness of the neck and shoulders?

Q. Did you find stiffness of the head?

A. Stiffness of the head, yes. That's the patient's chief complaint.

Q. Was there stiffness of the neck?

A. Yes.

Page 42-continued

Q. Was there stiffness in the shoulder?

A. Yes

Q. Was there stiffness in the spine?

A. Yes

Q. So you found a general stiffness in the head, neck the shoulder and spine.

A. That's right. That's true.

Q. In addition, did you turn the patient's head from left to right?

A. Yes, I did , yes.

Q. And in turning the patient's head from left to right, what did you find?

A. I found the patient had a limitation of movement of the spine limited to turn left and right.

Q. When you turned the patient, did you turn the patient's head from right to left in the other direction?

A. Yes, I did.

Q. And what did you find?

A. From left to right, the patient have about 10 degrees of movement. It's about 10-15 degrees of movement. On the left side , it's about 10 degrees.

Page 43-44

ln. 16 Q. And was that helped by the acupuncture treatment?

A. By the time of the treatment, I find that they talk about calcifying of the ligaments and the spine, and I recommend the patient to see a specialist. Yes, after I found the stiffness of the spinal cord and I recommend him to check with his medical doctor, and I said this will be related to some other problem and only do--
and I only can do this to relieve his stiffness of muscle and the headache problem by the moment. The patient agreed and continued for the treatment for relieving the stiffness of the shoulder and headache.

Q. Diplomate Deng, did you ever at any point have the patient lie completely flat on the examining table?

A. By that time I asked--I did ask him to lie down, and the patient had difficulty to move. Have to step on a stool and then he can lie down on the bed.

Q. Now, when the treatment was finished, did the patient get up on his own, or did he have to--
-did you have to help the patient get up?

A. Of course, I have to help the patient.
The patient is difficult to lift by himself, and I help him to lift up. Then, he can stand up.

Q. So that in every case where the patient was lying on the examining table and the acupuncture was finished, you had to help the person, you had to help the patient sit up?

A. Yes

Page 45

ln. 10 Q. In the first examination on 7-6-96, did you get a chance to view the patient perfectly flat on the examining table, in other words lying down flat?

A. Well, the patient has difficulty lying down flat. The head cannot touch. The rear of the head cannot touch the surface of the table, so he needs a higher pillow to sit up under his head so he can lay down comfortably.

Q. And you're certain the head did not touch the examining table.

A. Yes, I am certain about it.

This concludes reading portions of Diplomate Deng's testimony of what existed on 7-6-96. Back to questioning Diplomate Felder MD

Q. From the pages I've just read you, Diplomate Felder, does that reinforce your opinion of ankylosing spondylitis on 12-5-96?

A. Yes

Q. And why would that reinforce your opinion?

A. Because again, it brings out the limitation in movement of a patient having ankylosing spondylitis, in my opinion.

Page 48

ln. 12 Q. Diplomate Felder, do you see any evidence of quality control procedures applied to the face of that form (encounter form) by Dr.Mancall or any institution?

A. I can't say that I do, but I'm not exactly sure what that would mean.

Page 49

ln. 4 Q. Okay. Dr.Mancall, in his deposition, has indicated that the first paragraph, the top of that form was written by a medical student who he does not recall the name of the medical student. In your medical opinion, is--would it have been important for him to make sure that the name of the medical student was noted before he signed the bottom of that form?

A. Well, in my opinion, usually the medical student signs and the attending physicians sign.

ln. 19 Q. Would the signing of that or putting a notation by the medical student, would that assist at a future date if the doctor had questions about the completeness of the medical history?

A. Yes, it could.

Page 50

ln. 13 Q. Do you have Dr. Waterman's deposition?

A. Yeah, okay.

Q. On 9-15-99, Dr. Waterman wrote a letter to Dr. Kellman in which he stated that he had treated the patient and that he had taken radiographs and he goes on to say those X-rays reveal that he does have indeed, have a spondylarthropathy, which I had suspected.His x-rays are compatible with a diagnosis of ankylosing spondylitis.

In addition, this type of spondylitis may be secondary to the aforementioned history of inflammatory bowel disease. I spoke with Mr.Maresca on 9-15-99. I told him that he would probably benefit from either a nonsteroidal anti-inflammatory, Indocin or sulfasalizine .

He has been on sulfasalazine in the past for his inflammatory bowel disease & actually tolerated it quite well. I instructed him to get in touch with you since he regards you as his primary care physician.

I feel uncomfortable prescribing medications like this at such a long distance. It would be impractical for him to come to the UCONN in Farmington on a regular basis for monitoring these medications. I also mention the fact that he could, perhaps, be referred to a local rheumatologist who could monitor his care.

The dose of indomethacin that is usually used for spondylarthropathy is 50 milligrams TID.

Sulfasalizine is given in a total dose of approximately two to three grams per day, usually in divided doses, BID.

Both these medications have been shown to be effective in the treatment of inflammatory back disease.

Signed
Dr.John R. Waterman MD
Assistant Professor of Medicine

Admitted Trial Exhibit 94 and 95 of Dr.Waterman Rheumatologist with a finding of Ankylosing Spondylitis at the 9-15-99 measurement date, a description of a great deal of musculoskeletal problems and the need for an inflammatory back pain protocol to deal with inflammation.

And Dr. Kellman has admitted to reading this letter.

Page 51

ln. 23 Q. In your medical opinion Dr. Felder, what is the sulfasalazine accomplishing?

A. I would think decreasing inflammation.

Q. And what would indocin accomplish?

A. It's a nonsteroidal anti-inflammatory agent that would decrease inflammation.

Page 53

ln. 3 Q. Okay. You read the deposition of Dr.John Waterman completely.

A. Yes I have

Q. As well as Exhibits?

A. Yes

ln. 15 Q. And in reading the deposition of John Waterman, is it your medical opinion that that deposition reinforces your belief that the existence of ankylosing spondylitis was in place as of 12-5-96? Does that reinforce your suspicion that it was in place?

Page 54

ln.1-10 A. It is my opinion that would be correct. That at the encounter, the original encounter that you had --someone took my letter--with--let me pull it out here. That on your 12-5-96 visit, you did have, it would be my opinion at that time, point in time, ankylosing spondylitis and symptomatology thereof.

Q. Okay. If you would go to Pg. 24 of Dr.Waterman's deposition , Lines 15 to 22?

A. Yeah

[Diplomate Felder begins to read from Dr. Waterman's deposition.]

Page 54 continued
ln.14 Q. He's talking about the importance of daily exercises.

A. Yes.

Q. Okay. Is it your-would you concur that his conclusion that the patient wasn't doing daily exercises at that point, would you concur that was an important element of the patient's treatment?

A. I would concur with what Dr. Waterman is saying here.

Q. Maybe if you could read what he is saying here.

A. (Diplomate Felder reading) Starting ln.15 p.24

Page 55-6
ln.1 Q. Yes

A. Question, in your examination of the patient, was it obvious to you that the patient was or did you elicit from the patient whether or not he was doing daily exercises, as opposed to periodic exercises?
Answer by Dr. Waterman- I don't think that is noted.
Was it evident that the patient was doing daily exercises? I should say not . (By Dr. Waterman)

A. --when you examined the patient, did you turn the head from left to right? Answer- yes. Did you find a normal range of motion?
Answer- No.
What did you find? Answer, decreased cervical range motion in all directions, both passive and active.

Q. Okay, Diplomate Felder, could you define what decreased cervical range of motion would mean?

A. That would be decreased range of motion in all directions, is what he's saying here, of the neck, of moving your head back and forth, up & down etc.

Page 58

ln. 18 Q. Okay. Diplomate Felder, have you seen this encounter form of Dr. Carter Abel?

A. I believe I have yes.

Q. Okay. And if you'll draw your attention to the top of that form which was prepared 7-28-1999. It preceeds the examination by Dr. Waterman.

Q. Okay. Diplomate Felder, what is on the face of this 7-28-99 encounter form of Diplomate Abel?

A. Exhibit 135

Q. Yes

Page 59

ln.1 A. Says visits, Mr.Joseph Maresca, Bronxville, NY, your date of birth under history and physical. Do you want me to read this or-

Q. Just the first part where it's talking about the iron hand.

A. Oh, feels like, quote, iron hand, end of quote, on scalp pulls upward for more than 3 years duration.

Q. Is that notation consistent with the existence of ankylosing spondylitis?

A. Yes

Q. Why would that be compatible with the existence of ankylosing spondylitis?

A. Because it's showing limitation of movement and greater than 3 years duration.

Page 59 continued

ln. 17 Q. Okay, if you will go down further on the form,there is a notation see rheumatologist to evaluate for autoimmune disease, including blood work-ups. Would you agree with the assessment by Dr. Carter Abel?

A. Yes, I think that's good.

Q. Why is that a reasonable assessment?

A. Because a blood work-up would help give further information on why you're having symptomatology, such as stated in Harrison's Textbook of Medicine,

Page 60 looking at HLA-B27 , for example.

ln. 2 Q Okay. And also attached to that is the blood work showing the SED rate, the sedimentary rate?

A. Yeah

Q. Now , is that a normal SED rate being reported?

A. No, it's elevated. The reference range is 0-30. You had 38.

Q. And , is that indicative of a more profound problem in the body system?

A. It would be indicative of a problem yes.

Q. Okay. And also I'd like to show you Exh.112-114. These are exhibits of Dr.Terraciano and the Exh. of Dr.Joseph DeCarlo. These I believe you have noted in your report, the existence of the Iritis. If you could tell us, what is on those exhibits?

Page 60

ln. 19 A. This is an eye exam saying 5-29-97, showing with a diagnosis of Iritis, the left eye, OS.

Q. And Diplomate Felder, is the existence of iritis in the May 1997 time frame, is that a potential marker for ankylosing spondylitis, in your medical opinion?

A. Yes, it is listed in Harrison's Textbook of Medicine.

Q. And why would that be a marker for ankylosing spondylitis?

A. Well, it could be one of the symptoms that a patient having ankylosing spondylitis could have. Here to quote Page 1950 acute anterior uveitis (iritis) occurs in a least 20% of patients with ankylosing spondylitis.

Page 63

ln. 8 Q. Diplomate Felder, would you kindly summarize the types of difficulties the patient complained of and that, in your neurologic opinion, you felt were indicative of ankylosing spondylitis?

A. Well, the patient yourself had numerous symptoms, rigidity of the head, neck, spine, loss of range of motion, difficulty, for example using a computer, extensive talking has become difficult for you. Oh here, I did say that you developed Iritis on 5-20-97, yeah, I did apparently note that somewhere. That you've had Crohns Disease, it's been exacerbated. You've had tinnitus, which is sounds-a sound of noise in the ears.

Difficulty going over in bed, moving around in bed, I should say. Tying your shoes, putting on socks, trembling of hands, feet, occasional feelings you've stated that your body seems to freeze up.

ln.24 Q. Okay. Diplomate Felder, have you read the Mortality Among Patients With Ankylosing Spondylitis Not Given X-ray Therapy, by E.P. Radford, 9-15-77, Vol.297
Pages 572-576 of the New England Journal of Medicine?

A. Yeah, I did see that [Referenced Trial Exhibit 279]

Page 65

ln. 5 Q. Okay. Back on the record utilizing Civil Rule 803.18, which allows the discussion of scientific journal medical journal type information, given this article Mortality Among Patients With Ankylosing Spondylitis Not Given X-ray therapy, this article mentions that these results of 836 patients with ankylosing spondylitis investigated indicate,at least in men, ankylosing spondylitis has life-threatening consequences related to many
organ systems, consistent with systemic vascular degeneration as one long-term consequence of the disease. In addition, mortality risk relative to the general male population was fourfold for all gastro-intestinal disease, nearly twofold for accidents, suicide & cerebrovascular disease and 40% in excess for other circulatory diseases.

Page 65-66

ln. 22 Q. Dr.Feldman, do you believe that statement in the abstract of the New England Journal of Medicine, a scholarly medical journal, that that abstract would fairly describe the risks of ankylosing spondylitis?

A. In my opinion. Yes

Page 66

ln. 17 Q. Okay. And would you agree that the plaintiff had those types of risks during the period 12-5-96 (the date of Dr.Mancall's exam) to 9-15-99, the date of discovery of the ankylosing spondylitis?

A. Yes.

Bradley Goewert, Esq.-Cross-Examination

Page 81

ln. 8 Q. And now you sit on the Board of Nutra Pharma Corp.?

A. That's right (Diplomate Felder-continued)

Page 84

Ln. 10 Q. All right- and that's you agree, Dr. Felder, that headaches are not a sign or symptom of ankylosing spondylitis?

A.It's my opinion that headaches can be a secondary symptom of ankylosing spondylitis and that the neck is connected to the head, and if a patient has a great deal of cervical neck problems, it can cause possibly headaches.

Page 85

ln. 16 Q. Do you agree that chronic tension headaches was an appropriate diagnosis?

A. Yes, it is a diagnosis of one of Mr.Maresca's symptoms.

Page 110

ln. 20 Q. Would you agree that there's no known medication which has clearly been shown to alter the natural history of the disease?

A. That's correct.

Q. Okay.

A. Its treatment of symptomatology.

Q. You treat symptomatology?

A. Yeah.

Page 114

ln. 21 Q. Under the Civil Rule 803.18, this is a scholarly document, Kelley's Textbook of Rheumatology. It states on page 1049 that overall, the first 10 years of disease is particularly important with respect to subsequent outcome. Dr.Felder or Diplomate Felder would you agree with that statement?

A. Yes. I agree with the statement.

Page 115

Ln. 3 Q. Does your opinion change based upon the cross-examination of Bradley Goewert in terms of writing your letter, what you have heard subsequently, does that change your opinion in terms of the 11-22-02 letter that you wrote?

A. Well, my letter was based upon the documents I was given, and I reviewed them, I spoke with you, and I came to those conclusions.

Q. Have those conclusions changed?

A. I would say I still hold those conclusions.

Q. All right. Based upon the letter given to Dr.Mancall in the 12/96 examination describing the inability to do a sit-up or to run, are those still very important things that have been brought to Dr.Mancall's attention that are pertinent to a diagnosis of ankylosing spondylitis?

A. Well , they would be pertinent.

Trial Exhibit 43

Evidence entered prior to the close of Plaintiff's Case in Chief
Exhibits 43-53

PATIENT DATA-Maresca
THOMAS JEFFERSON UNIVERSITY HOSPITAL
HISTORY PHYSICAL EXAMINATION
PROGRESS NOTES
DEPARTMENT OF NEUROLOGY USE ONLY
12-5-96
cc: Headaches @ 7 mo.
HPI: Headache x 7 mo. duration. HA'S worsen late in day & after typing on computer. Believes these are tension HAs. Pain is non-localized involving entire head. Pain relieved by external pressure to scalp. HA occasionally accompanied by tingling in fingers. HA episodes occur every day & throughout
each day.Has been wearing waist support belt to help c HA symptoms. Believes that pulling in stomach c belt lessens pulling of facial muscles which relieves pain. HA relieved by lying down.
PM Hx: Crohn's Disease- diagnosed '91
L4-L5 disk- diagnosed '91
PSH: Theta symbol
Medications: None
ALL: Penicllin
OE: OBESE BP:140/80
MENTATION-CHECK LANGUAGE-CHECK
Cranial nerves all normal. Fundi check meaning normal.
Motor strength, bulk, tone, check means normal(note obese)
Deep tendon reflexes are 2+, equal Plantars PL-downgoing
Cerebellar function normal. Sensation normal.

Trial Exhibit 43-continued

Diagnosis, chronic tension headache.Rule out intraventricular tumor. Plan MRI, If Okay, Fiorinal, return post-MRI. Signature-Dr. Mancall MD scrawled

Source: Deposition of Dr. Mancall MD 7-24-02 p. 37 ln. 20

Witness: The part that I wrote personally is toward the bottom where it begins OE, standing for on examination. Everything above that I did not record. pp. 37 ln. 9-12

Trial Exhibit 44

Approved by the District Court prior to closing the Plaintiff's Case in Chief

Elliot L. Mancall MD Patient Office: Neurology Outpatient
834 Chestnut St.
Suite 420 Phil. Pa.
Academic Office: Thomas Jefferson University Hospital
Department of Neurology 1025 Walnut St.
Phil. Pa.

Name: Joseph S. Maresca Date: 12-5-96

Rx: MRI head c and s R/O intraventricular mass lesion

Signature: Dr. Elliot L Mancall License # DEA AM 2448240

Trial Exhibit 45
Approved by the Court prior to closing Plaintiff's Case in Chief
2-5-97
Elliot L Mancall MD
Neurology Outpatient Office
834 Chestnut St. Suite 420 Phil. Pa.

Dear Dr. Mancall:
RE: MARESCA, JOSEPH S.
MAGNETIC RESONANCE IMAGING OF THE BRAIN W/CONTRAST:

Imaging sequences consist of spin echo TI weighed sagittal & axial scans obtained pre and post injection of intravenous Galolinium contrast. T1 weighed coronal scans obtained post contrast, T2 weighed axial scans and multiecho coronal scans.

No masses or enhancing lesions demonstrated. There is evidence of cerebellar atrophy. No congenital abnormalities are demonstrated. The inferior border of the cerebellum appears to be just above the cervical occipital junction in satisfactory position. The brainstem is unremarkable in appearance. The auditory nerves appear intact. There is no evidence of edema.

There is no ventricular deformity or ventricular shift. There is no ventricular dilation or cortical atrophy. There is no evidence of an intraventricular lesion. There is no evidence of white matter plaque. There is no evidence of trigeminal neuroma. There is no evidence of other cerebral neoplasm. There is no evidence of cerebral infection. There is no evidence of aneurysm,

arteriovenous malformation, subdural hematoma, subarachnoid hemorrhage, cerebral contusion, cerebral infarct or pituitary
lesion.

IMPRESSION:

1. CEREBELLAR ATROPHY
2. OTHERWISE, NEGATIVE MRI SCAN OF THE BRAIN, OBTAINED PRE and POST CONTRAST.

SPECIFICALLY, THERE IS NO EVIDENCE OF INTRAVENTRICULAR MASS LESION OR OTHER NEOPLASM SUCH AS TRIGEMINAL NEUROMA.

David P. Gerstman MD, Radiologist OPG: ET/ ms
[NYS License 60 086 048 Dix Hills, NY]

Trial Exhibit 46-Approved by Court

Office of Dr. Elliot L. Mancall
Patient Office
Neurology Outpatient Office
834 Chestnut St. Suite 420
Phil. Pa. 19107 STAMPED : FEB. 13, 1997

Attention: Dr.Elliot L. Mancall MD
Regarding: Patient Joseph S. Maresca
Tension headaches, MRI

Sir,

As we discussed, I visited a local general practitioner, Dr. Filannino MD at 718-892-1447 for the follow-up treatment of this condition. He prescribed Imitrex at 25 mg. for a 30 day supply-final. The Imitrex appears to be the Sumatriptan used to constrict blood vessels. This would appear to be the treatment, although it is a powerful medication with side effects. The cost is also significant; however, I'm told that the medication works well in over half the patients-according to the pharmacists I've called.

The Pharmacist has suggested taking a portion of the prescription initially because it is so expensive (circa $380.). Sometimes the medication works well after just several pills. Others on this medication have told me that a few pills usually gives substantial relief and the remainder of the prescription is kept in case of a recurrence. I'm going to try this route unless you have objections with regard to taking the medication at this time.

Sincerely,

Joseph S. Maresca Feb. 9. 1997
Box 646 Bronxville, NY 10708-3602
914-649-3817

Trial Exhibit 47-Approved by Court

Valerie-Please show Dr.Mancall and file in my records

Feb. 15, 1997

Dr.Elliot L.Mancall MD
Neurology Outpatient Clinic Stamped 2-24-97
834 Chestnut St. Suite 420
Phil. Pa. 19107

Regarding: Tension Headaches/MRI/Treatment Imitrex 25mg

Sir,

Previously, we discussed that the MRI disclosed what was believed to be a normal shrinkage of the cerebellum and little else.

My local physician, Dr.Filannino, prescribed the Imitrex at 25 mg. to treat the tension headaches. After a week, I have a much improved circulation in the fingers. That is, I no longer experience the tingling. In addition, the tension in the upper palate of the mouth has reduced significantly. There is still some tension in the forehead which worsens at night.

I've asked Dr.Filannino to increase the dosage to 50 mg.pills. We discussed (he and I) that this option might clear up the remainder of the headache. Otherwise, we may have to try another medication or combination of medications. In addition, I will ask Dr.Filannino whether or not some arteriography might be helpful to highlight the status of the blood vessels in the head and neck.

The Imitrex (Sumatriptan) is sold in doses varying from 25mg.-100 mg. The 25 mg. pills are $12.88 apiece. The 50 mg. pills are $15. each and the 100 mg. pills are $18.50 apiece. Obviously, it is more efficient to upgrade the dosage rather than taking multiple pills at the 25 mg. level. For instance, it's cheaper to take a 50 mg. pill for $15. instead of 2@25 mg. pills costing well over $25. The 50 mg. pill produces a savings of $10 per pill over taking 2 @ 25 mg. pills.

Trial Exhibit 47-continued

I assume that you've examined the original x-rays forwarded to your office. Dr.Gertsman of the MRI group produced the report forwarded to you; however, I'd like to be assured that at least 2 physicians have examined the films in detail and come to the same or similar conclusions. I'm also concerned that the MRI has been taken and interpreted properly.

Sincerely,

Joseph S. Maresca 2-15-97

Box 646 Bronxville NY 10708

Exhibit 48-Approved by Court

Dr.Elliot L.Mancall MD
Neurology Outpatient Office
834 Chestnut St. Suite 420 Phil.Pa, 19107
Regarding: Joseph S. Maresca-Tension Headaches
50 mg. per day Imitrex/Sumatriptan

Sir,

My local physician, Dr. Filannino has increased the dosage;however, there is no permanent relief of this headache except at night when lying down. The Imitrex appears to relieve the tingling in the fingers; however, the tightening of the trigeminal nerve structures continues unabated.

I may need a medication which will liberate the nerve structures.
Perhaps, Haldol, Robaxin or one of the muscle relaxants is the prescription needed to deal effectively with loosening the trigeminal nerve structures which appear to be quite frozen and rigid. I have a small personal acupuncture appliance which delivers som e measured electrical stimulation to the forehead. This breaks up the tension into smaller components. It helps but it is not a permanent solution. At most, the acupuncture translates
a frozen facial mask into smaller pockets of tension evenly distributed from the forehead to the throat.

Kindly consider all of the above and advise me as to which direction might provide a permanent resolution of this headache.

Sincerely,
Joseph S. Maresca, patient
Box 646 Bronxville NY 10708
914-649-3817

Exhibit 49-Approved by Court

Dr. Elliot L Mancall:Hahneman Hospital

Patient: Joseph S. Maresca

Box 646 Bronxville NY 10708-3602

Tel: 914-649-3817

Time frame of last visit: 3rd Q of 1991

Diagnosis: L4 and L5 disk problem

Technique-Coronal T1, sagittal, double echo and T1 as well as axial T1 images were obtained providing good spatial resolution of contrast.

Test Results: The normal lordotic curve is preserved. Degenerative changes of the intervertebral discs with loss of disc height and dissecation is noted at the L4 L5S1 levels. Central bulging of the anulous fibrosis is noted at the L4-5 level without evidence of thecal sac impingement. The epidural fat is preserved . At the L-5 S-1 level herniation of the nucleus pulposus is noted in right paramidline distribution causing

effacement of the thecal sac. This material is noted in the inferior portion of the L5 neural foramen without significant canal stenosis.

Degenerative changes of the intervertebral disk at the L4-L5 and L-5-S1 levels. Central disk bulge at the L4-L5 level. Right paramidline herniation of the nucleus pulpous at the L5-S1 level causing effacement of the thecal sac at that level.

by Luigi Arena MD [NYS License 60 174 471 Yonkers]

by Zelig Weinstein MD [NYS License 60127373 Monsey]

Referred to: Dr. Frederick Simeone MD
Suggestion: Surgery was not recommended after a review of MRIs.
Therapy: Dr. TV Seshan MD 914-347-3884 Physical Medicine and Rehabilitation

Moist head. Cold packs Ultrasound Electrical Stimulation, Lumbar Traction Massage Spinal Extension Program Isometric Exercises and Ergometer at Lower Extremity
Frequency: 3 times a week for 4 months and wearing
Abdominal Binder indefinitely
Acupuncture applied

Effect: Gradually the patient returned to most activities including carrying heavy packages , light exercise, extensive computer terminal operation etc.

There appeared to be some permanent ability to do sit-ups and run at maximum speed. The abdominal binder is a necessity to prevent back pain.

Current Problem: Tension headaches with slight tingling of the fingers after arising from bedrest. These headaches gradually worsen during the day due to rapid keying of the computer keyboard. Areas of investigation-tension headaches, migraine, Probably not a tumor because pain subsides when lying down. Sumatriptan or trigeminal nerve injections

Exhibit 50-Approved by Court

Advanced MRI Imaging
Patient: Joseph S. Maresca DOB 1-14-52 Sex M
Date 8-17-91 MRI Exam-Lumbosacral spine

Order written by Dr. Mancall-Exh. 53

Technique: Coronal T1, sagittal double echo and T1 as well as axial T1 images were obtained providing good spatial resolution of contrast.

Findings: The normal lordotic curve is preserved. Degenerative changes of the intervertebral discs with loss of disc height and
dissection is noted at the L4 L5 and L5 S1 levels. Central bulging of the annulus fibrosis is noted at the L4 L5 level without evidence of thecal sac impingement. The epidural fat is preserved. At the L5S1 level herniation of the nucleus pulposus is noted in right paramidline distribution causing effacement of the thecal sac. This material is noted in the inferior portion of the L5 neural foramen without significant canal stenosis.
IMPRESSION:
Degenerative changes of the intervertebral disc at the L4L5 and L5S1 levels. Central disc bulge at the L4L5 level. Right paramidline herniation of the nucleus pulposus at the L5 S1 level causing effacement of the thecal sac at that level.
by Luigi Arena MD Zelig Weinstein MD
1201 Morris Park Av. Bronx NY 10461

Exhibit 53-Approved by Court

215-246-5010

Elliot L.Mancall MD

Neurology Ambulatory Care Center
1427 Vine St.
Phil. Pa 19102

Hahneman University
Broad and Vine
Phil., Pa. 19102

Name: Joseph Maresca Date 8-15-91

Rx MR entire spine
Dx : ? discogenic disease
chr. cervical and lumbar strain

Dr. Elliot L Mancall MD BNDD NO. AM 244 8240
Signed in script

Exhibit 55-Approved by Court

Neurological Associates at Hahnemann Univ. PC
1427 Vine St. First Floor
Phil. Pa. 19102
Appointments- 215 246 5010
Please Make Checks Payable to Neurological Associates
at Hahnemann Univ. PC

This is your receipt for this amount.

DOCTOR'S NAME: DR.MANCALL GR. 907
JOSEPH S. MARESCA

8-15-91 DATE
CONSULTATION-COMPREHENSIVE $200 FEE
90020
DIAGNOSIS: Chronic cervical and lumbar strain
CASH

Signed
Elliot L Mancall MD Rev. 5/9/91 #1721 form

Trial Exhibit 112-Approved by Court
Joseph S. Maresca
Box 646 Bronxville NY 10708
No Insurance

OD 325 12+ 95
OS 350 100 145

IRITIS O.S.

Al. Sulfate 1%
Maxiline A Oa at nite

Record of 5-20-1997

On 5-25-02 patient given report of medical exam for 5-20-97
Patient has Crohn's history.

Report of Dr. Joseph DeCarlo MD- Opth.

Trial Exhibit 114 -Approved by Court

Case 10634 Maresca, Joseph S.
Box 646 Bronxville NY 10708 5-29-1997
914-649-3817 DOB 1-14-52 Age 45 Sex M

Medical history of Crohn's Disease
L red eye 3 weeks
-3.25 = -1.75 x 180
-350= -1.0 x 45
1 squeeze
deleted pupil Ac Cli KP delta

-3.25 = 20/30 -4.5 20/50
fundi-dise macular OK
Pred Forte 17 OS Q/D
1 bottle Pred Forte 17
11-23-99 OS QID renewed prescription

Pasqual A. Terraciano MD
2241 Esplanade Av. Bx. NY 10469
718-654-7122

Trial Exhibit 135 - Approved by Court
Carter G. Abel MD-Diplomate 201567-5969
Maresca, Joseph S.
Box 646 Bronxville NY 10708-3602 914-649-3817
Referred by Dr. John McCarthy now deceased
Drug Allergies: Penicillan / Pollam
History and Physical Ht. 5" 7 240# BP 135/85
c/o scalp discomfort
o feels like "iron hand on scalp pulls upward--> 3 years duration
o improves after 3-4 hours of resting or sleep
o progresses throughout the day; denies trouble swallowing
REX: NEG for cervical, occipital, axillary, sup adenopathy today
Full Skin Exam: Face, abdomin, back, neck ears, scalp.
Negative for evidence of scleroderma-no plaques or loss of scalp hair or BCC, SCCar HM of this type on exam
Rosacea: Metrogal GID provided
Scalp tightness/Muscular Spasm
o see Rheumatologist to evaluate autoimmune disease including blood work-up for Lupus and other related
o Today there is no physical evidence or symptoms suggesting Raynaud's phenomena or scleroderma
Biopsy of scalp was offered but declined by patient.
Otherwise, no therapy is indicated at this time.

Trial Exhibit 135- Approved by Court--continued
Patient agrees to see Rheumatology and to pursue
blood tests in the near future. Shark Cartilage
MEDS: Intravenous Magnesium, B12, Calcium
Watch diet doesn't drink whole milk
PHH: Crohn's Disease and quiet recently
Oxidative Stress Test and Uses magnetic therapy
Physically active with max.computer 18 hours
Hands are dry and shiny but do not turn purple.
saw neurologist, cervical images reportedly OK
Elliot Mancall (Y/S) Thomas Jefferson Hospital
Ideal weight 160#
Myasthenia Gravis (test) NEG
Thyroid Tests Negative
R/O , if condition warrants it
Initialed : Dr. Carter Abel MD
Note : Trial Exhibit 136 shows paid bill $110 on 7-28-1999
692.70 Diagnosis 98204 Procedural Services

Trial Exhibit 117 - Consideration Taken Under
Advisement by the Trial Court

Dr. Dworkin MD-Surgeon 12-20-91
Ileocecal Valve Rectum

ADEQUATE PATHOLOGY EVALUATION REQUIRES HISTORY

Maresca, Joseph S. 39 years old
Box 646 Bronxville NY 10708

FEVER 1 increased WBC/ ESR
R/O Crohn's Disease , Increased AFB
Infection at Ileocecal Valve Area

D.Dworkin
Surgeon's Signature

Pathological Diagnosis: A) Ileocecal Valve: Ileal and colonic mucosa showing ulceration and granulation tissue with mild focal cryptitis and acute and chronic inflammation. No evidence of granulomata

B) Rectum (Biopsy) Colonic mucosa with focal lymphoid aggregates. No evidence of cryptitis-cryptal granlomata
The specimen is received in formalin in two parts.

Part A labelled Ileocical valve biopsy x 7" are 7 fragments of soft tannish tissue measuring in aggregate .8 x .2 x .2 cm. All tissue issued in cassette. B

Summary of Specimen A) B) Entire specimen
12-23-1991 R. Abbi, MD Pathologist Signature
[Note: Trial Exhibit 116 Sulfasalizine 1/2 gm. 3 times renew]

Trial Exhibit 279- Read by Diplomate Felder MD at Trial

Mortality among patients with ankylosing spondylitis not given x-ray treatment Vol. 297:572-577 9-15-1977
Vol.11 by EP Radford, R. Doll and PG Smith

ABSTRACT
We investigated age-specific mortality rates of 836 patients with ankylosing spondylitis diagnosed during 1935-1957. These patients were not given deep x-ray therapy, and thus their mortality was not confounded by possible late effects of radiation.
Follow-up observation was to 1-1-1968--on the average over 13 years from enrollment. Men had higher mortality than women; excess mortality was observed in men for diseases known to be associated with spondylitis, such as ulcerative colitis, nephritis and tuberculosis or other respiratory disease. In addition, their mortality rate relative to the general male population was fourfold for all gastrointestinal disease, nearly twofold for accidents, suicide and cerebrovascular disease and 40 percent in excess for other circulatory diseases. These results indicate that
at least in men, ankylosing spondylitis has life-threatening consequences related to many organ systems , consistent with systemic vascular degeneration as one long-term consequence of the disease.
THIS ARTICLE HAS BEEN CITED BY OTHER ARTICLES:
o Vildirir A. Aksoyek, Calguneri, M Aytemir, K. Kabakci, G. Ovune , K.

Expert Letter of Diplomate Felder MD for the Plaintiff
part A.76-79 of the Appellate 3rd Circuit Appendix
Faxed to Judge Legrome Davis and read into the
Trial Testimony of Diplomate Felder MD 1-16-04

Mitchell S. Felder MD
Board Certified in Neurology

Diplomate of American Board
of Psychiatry and Neurology

Suite 2
87 Stambaugh Av

Sharon Pa. 16146

November 22, 2002
RE: Joseph S. Maresca
Dear Sir/Madam,
I reviewed the medical records of Mr. Joseph S. Maresca and my medical and neurologic conclusions are based upon these records.

The records consist of: (1) deposition of Elliot Mancall, (2) deposition of Diplomate Deng 3) deposition of John Waterman MD and Exhibits

In summary, Joseph S. Maresca is a 50 year old male, DOB 1-14-52 , who on 12-5-96 had a visit at Dr. Elliot Mancall's office. At that point in time, the patient was complaining of significant headaches and lumbosacral rigidity. The visit took place at the Thomas Jefferson University Hospital. At the time of the visit, the patient could not do a sit-up or run.The patient had a history of Crohns disease over 5 years prior to the visit.

The patient was also complaining of progressive neck stiffness and stiffness of the facial and scalp muscles. Above Dr.Mancall's writing, an unknown person from Thomas Jefferson University Hospital noted that this patient had headaches of 7 months duration. The headaches worsened later in the day after typing or working on the computer.

Under the C.S. Par 6101-4 Sec 115.32 (e)
"A single signature on the face sheet of a record shall not suffice to authenticate the entire record. Each entry shall be individually authenticated. "
In addition, C.S. Paragraph 6101-4 Sec 115.33b of the Penn. Code deals with medical records. It reads as follows:
"Entries in the record shall be dated and authenticated by the person making the entry."

As per the deposition of Elliot Mancall, MD pages 12-20, the patient's head movements were not examined nor was there an examination of the spine, recollection of the patient's position while lying flat on the examining table, any deficiency of neck posture, evaluation of the pelvic area, examinations of rotations of the thigh, or recollection of difficulty in the patient getting off the table. Dr.Mancall's notations on the 12-5-96 medical records showed cranial nerves 2-12 to be intact, fundi to be within normal limits, motor strength muscle tone were found to be within normal limits, deep tendon reflexes were found to be 2+ symmetrically equal, planar response was flexor, cerebellar function was within normal limits.

The patient was actually given a diagnosis of Chronic Tension Headaches when the disease process present was Ankylosing Spondylitis in all likelihood. Mr.Maresca reportedly demonstrated a number of physical limitations to Dr.Mancall and a medical student who was in the office. However, this information was not reportedly recorded such as the fact that the patient had kyphosis where there was forward leaning of the spine approximately 15 degrees, and inability to do a sit-up, and the fact that the patient's head could not touch the wall while standing adjacent to the structure. Mr.Maresca had subsequently sent Dr.Mancall three (3) memos. Dr.Mancall did not answer or follow-up on the memos, and that follow-up probably would have lead to further investigation of this patient's condition. In the 2-13-97 memo to Dr.Mancall the patient related the fact that he was taking Imitrex. In a 2-24-97 memo, the patient was complaining of "some tension in the forehead which worsens at night". In a 2-26-97 memo, the patient complained to Dr.Mancall that the "tightening of the trigeminal nerve structures continued unabated". The patient was subsequently correctly diagnosed at UCONN Medical Group by John R. Waterman, MD, the Assistant Professor of Medicine. On 9-9-1999, the patient has a cervical spine with oblique views showing evidence of ossification of the anterior longitudinal ligament with bridging syndesmophytes and a suggestion of multi-lateral facet fusion with an impression of multi-level facet fusion

and a differential diagnosis of Ankylosing Spondylitis.On 9-9-1999, the patient had a lumbosacral spine which was AP and lateral showing multilevel facet overgrowth and calcifications of the infraspinous ligaments and fusion of the sacroiliac joints with an impression of multilevel syndesmophytes and ossification.

It is my medical and neurologic opinion that Mr. Joseph S. Maresca should have been ruled out for having ankylosing spondylitis at his visit with Dr. Elliot Mancall. This patient showed multiple features of a classical ankylosing spondylitis (AS Syndrome). As per Harrison's Principles of Internal Medicine , 15th Edition, "the inflammatory back pain of AS is usually distinguished by the following 5 features: (1) age of onset below 40 (2) insidious onset 3) duration greater than 3 months before medical attention is sought, (4) morning stiffness and 5) improvement with exercise or activity. Mr.Maresca fits all of these criteria. A diagnosis could have been achieved also by looking at the histocompatibility antigen HLA-B27.It must also be noted that AS is strongly associated with Inflammatory Bowel Disease both ulcerative colitis and Crohn's Disease. The fact that Mr.Maresca had a history of Crohn's Disease at the time of his original visit with Dr.Mancall would also help to rule out ankylosing spondylitis in the differential diagnosis for this patient.

In my medical and neurological opinion that the standard of care at the visit on 12-5-96 at Dr.Mancall's office was not appropriate for this patient's condition. Computed tomography and magnetic resonance imaging (MRI) are able to detect abnormalities at an early stage of ankylosing spondylitis, in fact, earlier than with plain radiography.

As per Harrison's Textbook of Medicine, it is noted that MRI has emerged as a highly sensitive and specific technique for identifying early intraarticular inflammation, cartilage changes, and underlying bone marrow edema in sacroilitis (Harrison's Principles of Internal Medicine, 15th Edition, page 1951)

During the 12-5-96 visit, Dr. Mancall ordered and the patient completed an MRI of the brain. The patient required a roentgenogram or MRI of the back. The need for a roentgenogram of the back was recognized, the order was written and the results were finally discussed with the patient by Dr.John Waterman on 9-15-99.

Another possible method for diagnosing this patient would be utilizing the New York Criteria (1984) which are widely used for diagnosis of this condition. This consists of (1) a history of inflammatory back pain, 2) limitation of motion of the lumbar spine in both the sagittal and frontal planes, 3) limited chest expansion relative values for age and sex and 4) definite radiographic sacroilitis plus any one of the other 3 criteria is sufficient for diagnosis of definite ankylosing spondylitis (Harrison's Principles of Internal Medicine, 15th Edition page 1951).

At the visit at Dr.Mancall's office 12-5-96, the Schober test would have been a useful measure for ankylosing spondylitis. This is a test in which the patient stands erect with heels

together and marks are made directly over the spine five (5) centimeters below and ten (10) centimeters above the lumbosacro junction. The patient then bends forward maximally and the distance between the two marks is measured. The distance between the two marks increases five (5) centimeters or more in the case of normal mobility and less than four (4) centimeters in the case of decreased mobility (Harrison's Principles of Internal Medicine, 15th Edition page 1950)

Mr.Maresca has stated that he suffered numerous difficulties secondary to the non-diagnosis of his condition. Namely, 1) continuing rigidity of the head, neck and spine and restriction of torque movements, 2) loss of range of motion 3)keying on the computer was downgraded and began to involve incrementally more pain 4) extensive talking/lecturing became more difficult for him , 5)difficulty with diaphoresis, 6) the patient develops iritis 5-20-97, 7) Crohn's Disease was reportedly aggravated, 8) the patient had tinnitus bilaterally with a hissing sensation, 9) the patient found turning in bed more difficult, 10) patient has difficulty turning book pages 11) the patient has had difficulty operating instruments ; such as a keyboard 12) patient has difficulty tying his shoes and putting on socks, 13) patient is unable to do a sit-up or get up from an examining table unassisted, 14) the patient has trembling in his hands and fingers and 15) the patient ocassionally states he has entire body freezing.

It is my medic[illegible]d neurologic opinion that these difficulties related to his u[illegible]gnosed condition Ankylosing Spondylitis in all likelihood.

As per the Harrison's Principles of Internal Medicine, 15th Edition, page 952, it is stated that with ankylosing spondylitis "participation by the patient in an exercise program that is designed to maintain functional posture and to preserve range of motion. There is evidence that exercise increases mobility and improves function. The proportion of patients with severe deformity has decreased markedly in recent decades, probably because of earlier diagnosis and widespread use of physical therapy." It also stated that "the peripheral arthritis may also respond to the folic acid antagonist methotrexate." Harrison's Principles of Internal Medicine, 15th Edition, pager 952, stated other possibilities for paliative treatment which would be intralesional or intraarticular glucorticoid injections and CT guided glucorticoid injections into the sacroiliac joints.

It is my medical and neurologic opinion that Mr.Maresca has had an exacerbation of his condition due to the lack of treatment of his condition Ankylosing Spondylitis. This increased his symptomatology by approximately 50% over the 3 years prior to when he was properly diagnosed. It is my medical and neurological opinion that Mr.Maresca had ankylosing spondylitis of his original 12-5-96 appointment with Dr.Mancall.

There should also have been follow-up visits by Mr.Maresca arranged by Thomas Jefferson University Hospital.

The lack of follow up by the Thomas Jefferson University Hospital considerably increased the chances that the condition Ankylosing Spondylitis went undiagnosed and substantially untreated. The hospital had a non-delegable duty to the patient to ensure that its policies, procedures and standards operated to deliver the medical diagnostic and treatment services requisite to identifying and treating the disease Ankylosing Spondylitis.

In the case of Joseph S. Maresca, these visits probably would have lead to an earlier discovery of his condition because the patient was providing quality feedback on range of motion issues pertinent to the diagnosis.

Philadelphia, Pennsylvania , in my medical opinion typically has one of the highest standards of care in the U.S. In my medical and neurologic opinion, Dr.Mancall, as a neurologist, should have been able to diagnose AS, as noted in the above criteria.

I hope that this letter is of benefit to you in your continuing evaluation of Mr.Joseph S. Maresca. Please feel free to call me should you have any queries concerning this medical report.

Yours truly

s/ Mitchell S. Felder MD, Board Certified Neurology

Diplomate American Board of Psychiatry and Neurology

IN THE UNITED STATES DISTRICT COURT FOR
EASTERN DISTRICT OF PENNSYLVANIA
JOSEPH S. MARESCA CIVIL ACTION
v.
ELLIOT L. MANCALL, MD, et al. NO. 01-5355
Philadelphia , Pennsylvania
May 4, 2004

BEFORE: HONORABLE LEGROME D. DAVIS, JR.

TRIAL EXCERPT-TESTIMONY OF DR. LEE MD, PHD.
NEW YORK MEDICAL COLLEGE 6/1998 PHYSICAL
MEDICINE AND REHABILITATION
AMERICAN BOARD OF MEDICINE/REHABILITATION
TREATING PHYSIATRIST
8-20-02 DEPOSITION READ AT TRIAL

APPEARANCES:
FOR PLAINTIFF: JOSEPH S. MARESCA, PRO-SE
BOX 646 BRONXVILLE, NY 10708

FOR DR.MANCALL: BRADLEY GOEWERT,ESQ.
1845 WALNUT ST.
PHIL. PA. 19103

FOR THOMAS JEFFERSON UNIVERSITY HOSPITAL: DOROTHY DUFFY, ESQ.
O'BRIEN AND RYAN
HICKORY POINTE
2250 HICKORY ROAD
SUITE 300
PLYMOUTH MEETING
PA. 19462-1065

COURTROOM DEPUTY: MARCELLA EL SHABAZZ

The morning of 5-5-04, Messrs. Maresca (Plaintiff), Goewert, Esq. and Duffy Esq. took turns reading excerpts from Dr. Lee MD's testimony . The testimony was read verbatim before The Honorable Legrome Davis, his deputy, the Court Reporter & jury. The Honorable Davis ruled on entering each excerpt into the record the morning of 5-5-04 before the jury entered the room. Once the jury entered, the parties read the following approved excerpts:

BY THE PLAINTIFF-JOSEPH S. MARESCA

Page 4-5

ln. 20 Q. All right. Dr.Lee, if you will go over, just give us an overview of on 8-14-01 what you did in our first meeting.

A. (Witness-Dr. Simon Lee MD, PhD) Yeah. 8-14-01 I saw Mr. Maresca, and he presented some x-rays, actually at that time was referred by Dr.Deng. And I saw Mr. Maresca and I reviewed the x-ray, and I provided a Schober test for Mr. Maresca, then some general physical examination.

And then the Schober test would show that the two centimeter changes which was below the normal number, which gave a diagnostic value for the ankylosing spondylitis for cervical spine, lumbar lumber spine. And then I referred Mr.Maresca back to continue the acupuncture therapy and home exercise program. Yeah, that's all in the first visit.

Page 7- line 13-21 (Dr.Lee MD PhD took a comparison x-ray of 8/2001 to 9/9/ 99 Dr.Waterman's x-ray)

Q. But when this says there is no interval change, does that indicate to you that the disease process is stable or dormant?

A. Based on my experience yes.

Q. In combination with the Schober test, because you've done a measurement from 2001, and a measurement just about three weeks ago, the Schober was your finding two centimeters?

A. Yes

Page 8 Q. Well, if I do extensive computer keying and that aggravates the disease process, should I do an occupation that does not involve extensive computer keying?

A. Yes

Page 10 Line 7-16 Objection sustained by Judge Davis

The plaintiff asks that the Supreme Court over-rule this objection and enter these lines into testimony because they shed light on the disease process and provide the Court with useful information from an authoritative source.

Q. Also with this disease, ankylosing spondylitis, do you accept the premise that early diagnosis is very important?

A. Yes

Q. And also, is continuity of care important?

A. Yes

Allowed Testimony
Page 10 ln. 17-19

Q. And also, is daily exercise important as opposed to exercising every week?

A. Yes

Page 12 ln. 9-21

Cross Examination -Bv Mr. Goewert, Esq.

Q. Dr. Lee, my name is Brad Goewert. We just met when I came into the room. I represent Dr.Mancall, who has been sued by Joseph S. Maresca.
My question to you is this, when do you normally make a notation of information as part of your medical record?

A. Right after the exam, that day. And I rewrite it.

Q. And when would you re-write it?

A. Like about two weeks ago, just because they needed a formal medical record.

(There was a request for medical information from the defendants to Dr. Lee MD, PhD and he summarized highlights of his examination due to the formal request. This was done without the plaintiff's knowledge but received by the defendants.)

Page 13 ln. 6-10 and ln. 19-21 Pg.14 ln 1-20 continued cross-examination.

Q. And Mr.Maresca had provided as an exhibit in my client's Dr.Mancall's deposition, a report dated 8-14-01, and I show you that here. I think it was previously marked Exhibit 13

A. Right

Q. Would you please show me in the original medical file that you have with you today where a copy of that record would be.

Page 14 ln. 1-20 (Goewert, Esq.)

A. Should be in the chart. It's not there.
Q. Then you also have contained within the chart that's here with you today--
A. Right.
Q. --a handwritten note. Is that your handwriting?
A. Yeah, that's my handwriting.
Q. We'll mark that as Defendant's Exh. 1 or 2 whichever is the first one. We'll mark that two.
A. Right.
Q. Now, when would that record, that handwritten note of August 14 of 2001 have been written?
A. That's about two-four weeks ago.
Q. About August 7th or so, 2002?
A. Right.
Q. So approximately a year after the exam took place?
Q. Based on the theory no. Because I thought they would ask for this record for case purposes.

Page 17 ln. 5-13 (Goewert, Esq.)

Q. Is it your normal practice to create handwritten notes of exams approximately a year after they occur?
A. It's not create (creating something), because we just thought, to make it more formal, I mean, for anyone who wanted to look at the exam.
Q. Did you write this when Mr.Maresca came back 7-21-02?
A. Yes

Page 18 ln. 3-21 and Page 19 ln. 1-7

Q. My question is very simple. Was the note on 8-14-01, which is the long, handwritten note--
A. Right.

Q. --made when you saw Mr.Maresca on 7-21-02?
A. Yes
Q. Okay. Now the information contained within that note of 8-14-01 is supposed to represent your findings and information that occurred back on August 14 , 01 right?
A. Right
Q. Did you record any other information contemporaneous with that visit on 8-14-01, other than the four line hand-written note, which is Defendant's Exhibit
A. Usually, we make a quick note during the visit, and than after that we may complete the note. But at that time, somehow we didn't do it.
Q. So you didn't make any note other than contemporaneous with the visit on 8-14-01, you didn't make any other note other than that one that's Defendant's Exhibit 1, correct?
A. Right.
Q. Do you have an independent memory of the patient's physicalfindings as they would have existed back on 8-14-01
A. Yes

Page 21 ln. 6-11 (Goewert) ln. 16onward -Plaintiff's request

A. Okay. So the reason why I rewrote the record is I thought that it should go for a formal like deposition or whatever, somebody will ask for the record. I didn't you know append any basic information compared to my brief note of that visit.

Q. Right.

A. The basic thing is the x-ray, there's no change. It's a clear cut you know evidence of ankylosing spondylitis in the cervical spine and lumbar spine. And the Schober test was two centimeters based on my examination.

Page 22 ln. 5-19 (Goewert, Esq.)

Q. And my question is, where did you get that information from, that's part of the physical exam that you wrote in 8/2002 for a visit on 8-14-01.

A. By my memory.

Q. Had you ever seen Mr.Maresca prior to 8-14-01?

A. He comes in for acupuncture. We saw him, you know, every week.
We just, because at that time he was treating with Dr. Deng. And then we just talked casual conversation. And also, I checked him (the patient) from time to time, but we didn't have an official patient care relationship yet. I do , you know, see him for a long time--for months.

Q. When?

A. I mean, since early 2001.

Page 23 ln. 1-2 and ln. 8-18

Q. Right. My question, though , was prior to Aug.14 of 2001, did you see Mr.Maresca?

A. Right.

A. I saw him in the treatment room. But, it's not like a doctor/ patient relationship.

Q. Fair enough. And that was in 2001?

A. Right

Q. Now, did you see him at all prior to 2001?

A. I don't remember.

Q. Did you ever see him back in 1996? Did you obtain a history or receive information from Mr.Maresca, a detailed history, about his medical condition, prior to the visit you saw him.

A. No

Page 24 ln. 7-20

Q. Dr.Lee, as part of your initial exam, you take a history of the patient; is that correct?

A. Yes.

Q. Did you obtain a detailed history from Mr.Maresca regarding his medical condition prior to the period of time which you saw him; is that right?

A. I didn't

Q. Is that right?

A. Yes

Q. You also did not obtain copies of some or all of Mr.Maresca's prior medical records; is that true?

A. No

Page 25 ln. 13-21

Q. That's part of my question. It's very simple. You saw him on August 14, 2001.

A. Right

Q. And prior to that, there is a series of x-rays that were done at Central Imaging Associates dated 8-8-2001.

A. I remember, because at that time Dr.Deng asked me, he said he is unable to write an order for an x-ray. He consulted me - this patient needs an x-ray at that time. Yeah, I wrote an order for an x-ray for Mr. Maresca.

Page 27 ln. 1-11

A. I saw him-

Q. Did you see him as a patient prior to that period of time?

A. I didn't write any note at that time.

Q. Was he a patient prior to that? Did you see him as a patient before you wrote an order for the x-ray?

A. At that time, no. I went to write an order as I tried to cooperate with Dr.Deng's treatment because he didn't officially refer the patient for my treatment.

Page 28 ln. 2-9 and Plaintiff ln. 12,13

Q. Did you review the x-rays themselves?

A. Yes

Q. Do you have any training or specialty in radiology?

A. No

Q. How many patients do you have that have been diagnosed with ankylosing spondylitis?

A. Two or three. Couple of them.

Page 30 ln. 1-13 and Page 32 ln. 10

Q. I apologize for this, and I know you gave me an answer, but she didn't get it down on the record. So I need to make sure that there's a record of one of the previous questions.

Which is, is it your testimony that you had approximately a couple of patients that you had in practice over the past six years.

A. Right.

Q. With the diagnosis of ankylosing spondylitis?

A. Correct

Q. Would you consider Dr.Deng as an acupuncturist to be a primary care physician, as you understand the term?

A. Yes.

Page 33 ln. 10-17

Q. Now did you look at those films side by side yourself, the 1999 film and the 2001 film?

A. Yes.

Q. When you reviewed those films, did you have the radiologist's interpretation of those films?

A. Yes. Again, I cannot make any official conclusion out of the film. I just review it because I'm not the radiologist.

Page 34 ln. 2-21

Q. Right. Well, what do you mean you can't make an official conclusion?

A. Usually, the diagnosis should be made by the radiologist. I can agree or disagree with the conclusion. But I cannot draw the conclusion.

Q. All right. You, based on your experience, cannot draw a conclusion about what that x-ray film says--

Q. You mean

Q. Let me ask that question again.

Q. What do you mean when you're saying you can't make a conclusion, an official conclusion, about that x-ray.

A. I mean, I cannot like write a conclusion or like a formal deposition in a court activity, things like that. I can write out what I think.

Q. So you don't think that you would be qualified to make that ultimate conclusion; is that right?

A. Yes

Page 36 ln. 6-16

Q. Do you know who he works for? (meaning Mr.Maresca)

A. No (Dr. Lee MD)

Q. Do you know what his job duties and descriptions are?

A. No

Q. You would certainly not say that Mr.Maresca cannot work is that correct?

A. No. He has a lot of disabilities. I mean , based upon my opinion, he may qualify for the disability.

Page 37 ln. 12-17

Q. Now, the next time you saw him was 7-21-02?

A. Yes.

Q. And, you didn't see anything, any change in his condition from the previous visit? Is that fair?

A. Basically, the same-right.

Page 39 ln. 1-10 and 18-19

Q. All right. Did you see Mr.Maresca prior to 2001? In 2000 or prior to that.

A. No.

Q. So you don't know what his condition would have been in 2000.

A. No.

Q.--or prior to that?

A. No

Q. Is that correct?

A. Right.

Q. Are you aware that Mr.Maresca does karate?

A. No

Page 40 ln. 14-21 by Plaintiff

Q. Also, Dr.Lee MD are you a doctor of physical medicine?

A. Yes

Q. And registered in this state?

A. Yes

Q. And also you have a PhD

A. Yes- in Anatomy, Cellular Biology

Q. Have you ever seen this record before, Charles Deng's record.

A. I saw Dr. Deng's record.

Q. Okay. Focusing on this specific area, he's talking about pain and stiffness in the head, neck and shoulder area.

A. Yes

Q. And the date of this record is 1996. If you would take a look 7-6-1996.

A. Yes.

Page 42 ln. 4-17 Plaintiff over-ruled but request Supreme Court to review and over-rule this objection to form

Q. Okay. To you, Dr.Lee , does the pain and stiffness in the head, neck and shoulder have any meaning in terms of the foundation of ankylosing spondylitis?

A. Yes

Q. It does. How does that relate to ankylosing spondylitis?
A. Patient will feel stiffness and pain, because, you know, because cannot move their joint and spine, you know. And it may cause muscle tightness, what we call muscle spasm or pain.
Page 43 ln. 5-10 Plaintiff over-ruled but request Supreme Court to review and over-rule this objection to form.
Q. Okay. When he says that there is pain and stiffness in the head, neck and shoulders, is he qualified to make that statement?
A. Yes . (By Dr. Lee MD, PhD)
Page 43 ln. 19-21 and Page 44 ln. 1-4
Q. What's the relationship between you, Dr.Lee and Deng.
A. He's a physician treating patients here.
Q. Are you in practice together?
A. No. This is a multi-, you know discipline practice office. We have a physiatrist, we have acupuncture, we have a dentist , we have an internist.

Trial Exhibit 97

During the Plaintiff Case in Chief the Court took Exh 97-100 under advisement. The United States Supreme Court is asked to admit these exhibits into evidence. Defendants did not object when these Exhibits were offered.

Lee and Kong Physicians Patient: Maresca, Joseph S

8-14-01 Xray: L/S no changes comparison in study 2 yr. ago
DTD @B hip. sacroilitis:
C/S Ankylosing Spondylitis
Schobers : 2 centimeters

Script signature: S. LEE

Trial Exhibit 98

Central Imaging Associates Aug. 9, 2001
1234 Central Park Av. Yonkers NY 10704 9147931234
RE: Maresca, Joseph S
PT# CIA 26951
Dte.Exam 8-8-2001

Simon Lee MD
254 Canal St. Suite 4008
NY NY 10013 currently at 81 Elizabeth St.

CERVICAL SPINE:
HISTORY: Ankylosing Spondylitis
AP, lateral, and both oblique views were obtained & comparison to 9-9-1999. There is no interval change. Extensive ossification of the anterior longitudinal ligament is again noted with bridging syndesmophte s. Multilevel facet fusion is again noted. There is no radiographic evidence of foraminal stenosis. Disc space height is maintained. The prevertebral soft tissues are unremarkable.
IMPRESSION: Findings again are most consistent with ankylosing spondylitis. Differential diagnosis includes other seronegative spondylarthropathies.

LUMBOSACRAL SPINE

HISTORY: Ankylosing Spondylitis
AP Lateral and a coned down lateral view of L5S1 obtained. A comparison is made to 9-9-1999. There is no interval change.Again seen ossification of anterior & longitudinal ligament w/ bridging syndesmophytes noted. Disc space height maintained.There is multilevel facet arthritis & overgrowth.

There is normal vertebral alignment.

IMPRESSION: No interval change since the last study. Findings consistent with anky.spondylitis or seronegative spondylarthropathy. Multilevel facet arthritis.

Trial Exhibit 99

Central Imaging Associates
1234 Central Park Av.
Yonkers NY 10704 914793 1234

Aug 9, 2001
RE: Maresca, Joseph S

PELVIS
HISTORY: Ankylosing Spondylitis
A single AP view of the pelvis was obtained . There is fusion of the sacroiliac joint symmetrically. This is unchanged since the prior limbar spine series of 9-9-1999. There is mild degenerative change of both hip joints
manifested by subchondral sclerosis along the acetabular roofs. The symphysis pubis is unremarkable.
IMPRESSION: Degenerative changes of both hip joints.
Bilateral sacroilitis and fusion.
Thank you for referring this patient.

Blumberg MD

R: 10908\ T: 011008\10-11

Exhibit 100

Chinatown Specialty Physicians Aug 19, 2002 2:53 PM
Lee & Kong Physicians PC Patient: Maresca, Joseph S

7-21-02 : His condition is maintained at the same level as the previous visit, Receiving acupuncture 1-2times/week.
PE: AA0x3 Schober's Test: 2 centimeters (delta).
Impression: Patient's condition is similar as previous exam based on the Schober's test.
Plan: Continue current management

Signed

SLEE (script)

Expert Letter of Diplomate Epstein MD-Rheumatologist
Appellate 3rd Circuit Appendix

Pennsylvania Rheumatology Associates, PC
Pennsylvania Hospital
Section of Rheumatology
Barry Schimmer MD, FACP, FACR
Chief of Section Alan L. Epstein FACP, FACR

OFFICE NOTES
MARESCA, JOSEPH S.
10-11-02

Joseph Maresca was seen in consultation on 10-11-2002. The patient is a 50-year old white male who consulted Dr. Elliott Mancall in August 1991 due to difficulty getting up from a chair caused by pain in the lower to mid-back. An MRI scan is reported to have shown degenerative disc disease. The patient was seen by a physiatrist and a physical therapist, which helped considerably. Following formal physical therapy, the patient routinely participated in a home exercise program which controlled his symptoms. At about the same time the patient was known to have low grade fevers. He was evaluated at the Massachusetts General Hospital and Crohn's disease was suspected. The patient was referred for a colonoscopy which confirmed the diagnosis. The patient was treated with a 6 month course of Azulfidine and dietary changes. He did reasonably well from 1992 to 1995.

In late 1995, he noted stiffness in his neck with inability to touch his occiput to the wall. In 1996, stiffness persisted along with tingling in the forehead and a sensation of pulling upwards in the forehead. Six weeks of acupuncture was beneficial. The patient started karate in the hope of helping himself. Due to an inadequate improvement, he again consulted Dr. Mancall. His complaints at the time were an inability to perform sit-ups, the inability to extend his neck and the persistent pulling in the forehead. Dr.Mancall focused on his complaint of the headache. A muscle relaxant was recommended to be prescribed by his local physician.The patient reports that no attention was paid to spinal issues.His local physician prescribed Imitrex without much benefit. Chiropractic therapy was also of limited benefit. From 1996-1999 , the pulling in his forehead worsened., especially when using a computer keyboard or doing intense paperwork. The patient also noted stiffness in his head, upper chest and upper back. His head began bending forward more. Rotation of the torso became more difficult.The patient was concerned about scleroderma. He consulted a dermatologist who excluded this possibility.

A rheumatologist was recommended and the patient consulted Dr. John R. Waterman MD at the UCONN. X-rays of the cervical spine, performed in 9/1999,

revealed ossification of the anterior longitudinal ligament and findings consistent with multi-facet fusion. X-rays of the lumbar spine also revealed ossification of the anterior longitudinal ligament with evidence of extensive syndesmophyte formation. There was fusion of the sacroiliac joints. The patient was felt to have ankylosing spondylitis, likely related to his underlying inflammatory bowel disease.

The patient was referred back to his local physician for treatment with either Indocin or Azulfidine. He apparently did not receive either of these medications, however. He recalls receiving an intravenous infusion and dietary changes were recommended. The patient began feeling better in six months. He has been stable over the past 2 years. His upper extremities are fine. His neck is stiff, and it is difficult to move his head, but there is no pain. His mid-back feels tight. There is no mid-back pain however. The patient also denies any pain in his lower back. His shoulders and hips were fine. He is unable to bend to tie his shoes.He has difficulty putting on socks. He also has difficulty turning while he is driving. ROS: An extensive review of systems is non-contributory. PAST MEDICAL HISTORY: Past medical history is significant for Crohn's disease, lumbar disc disease, ankylosing spondylitis and one episode of Iritis. MED/ALLERGIES: The patient is currently taking only Glucosamine/Chondroitin supplements. He is allergic to penicillin.

SOCIAL HISTORY: He is single and works as an accounting systems. He does not smoke or drink.
FAMILY HISTORY: Is non-contributory.
EXAM: On physical examination blood pressure was 160/80. The skin was clear. HEENT examination was unremarkable. Examination of the neck revealed severe restriction in range of motion with an occiput to wall distance of 10 cm. Chest expansion was reduced as well. Examination of the back did not reveal sacroiliac tenderness. Lumbar motion was reduced with a modified Schober test of 2 cm. Lungs were clear and cardiac examination was normal. The abdomen was benign and without hepatosplenomegaly. On musculoskeletal examination, there was no synovitis. There was no edema. There were no sensory or motor deficits in the lower extremities.

IMPRESSIONS/PLAN:
The patient's symptoms of ankylosing spondylitis, outlined above, date the onset of his illness to 1995-1996. In reviewing the Jefferson Hospital records from 12-1996, there are no complaints recorded that would suggest a diagnosis of ankylosing spondylitis. Specifically, there is no mention in the history of neck stiffness and limited range of motion. The focus during the Dec. 1996 evaluation would appear to have been limited to headaches, felt to be muscular in etiology.

Treatment for ankylosing spondylitis should always include an exercise program to maintain range of motion and improved function. There is no solid evidence, however, that any medication actually improves the natural history of this illness.

Alan L. Epstein, MD
Assistant Clinical Professor of Medicine
University of Pennsylvania School of Medicine
ALE: MT #34

Discussion of Questions Presented

1. Did the District Court and Appellate 3rd Circuit err in awarding the Defendants the Motion as a Matter of Law despite the fact that the plaintiff offered testimonial and documentary evidence that Dr. Mancall's 12-5-96 exam, mis-diagnosis, non-monitoring and lack of treatment was a substantial factor in the increased risk of harm to the patient/plaintiff and that his attachment to the Jefferson Medical College places him in the Thomas Jefferson University Hospital by his testimony, the fact that the logo of the Hospital is on the encounter form and the Jefferson Medical College belongs to the Thomas Jefferson University Hospital, Inc. registered to the Secretary of State.

> "Accordingly, if a plaintiff has proven that the physician's breach increased the risk of harm, then there is sufficient evidence to overcome a motion for judgment as a matter of law. The expert, in cases of this nature has been permitted to testify under the relaxed degree of certainty enunciated in Sec. 323a of the Restatement (Second) of Torts, that the defendant's failure to exercise reasonable care in the diagnosis and treatment was a substantial factor that increased the risk of harm." Eaddy 694 A 2d at 642 citing Billman 761 A. 2nd at 1212-1213.
>
> [5-7-04 decision of the Honorable Judge Davis]

> " The OIG believes that a hospital's written policies and procedures should take into consideration the regular exposure for each function or department of the hospital. Consequently, we recommend that the independent policies and procedures be coordinated with the appropriate training and education programs with an emphasis on areas of special interest by the OIG through its audit function, The OIG concurs: "risk areas include teaching physicians & resident requirements for Teaching Hospitals. "
>
> FR Vol. 63 #35 MONDAY 2-23-1998 P. 8990

2. The Court is asked to establish whether or not the current Pennsylvania Medical Malpractice law in its implementation and interpretation by the Pennsylvania Court System provides a uniform and fair method of determining causal connection of plaintiff's harm to the defendant's breaches and causal relationships for evidentiary purposes at the conclusion of the Plaintiff's Case in Chief and by extension to the Defendant's Case in Chief and the subsequent instruction by the Trial judge to a jury of peers.
For the disease process Ankylosing Spondylitis, disease causation and cure is not known definitively. There is certain harm when a plaintiff does not receive a definitive diagnosis, monitoring and treatment for years.
The disease ankylosing spondylitis is in the nature of a MINE claim as defined in (Question 3)

Professional negligence in the nature of medical malpractice consists of (1) a duty owed to the plaintiff (2) a breach of that duty by the physician and/or institution (3) a causal connection with plaintiff's harm (4) a direct link between the harm and plaintiff's damages .

Mitzelfelt v. Kamrin 526 Pa. 54, 62, 584 A 2nd 888 891,'90

The Trial Court confused causal connection with the lack of a cure for the disease Ankylosing Spondylitis. By law (3), the disease is in the nature of a MINE claim ; wherein, medical improvement is not indicated. The goal of disease treatment is management and containment of disease progression i.e. in later in life Tay Sachs or Sickle Cell Anemia.

The Court is asked to apply a consistent rule structure; such that, a reasonable person would infer a causal connection between the claimed pain and suffering and the negligence of the practitioner. The law, as described in the Metzelfelt case requires only a causal connection between the physician's negligence and plaintiff's harm.

The Pennsylvania Courts and even some attorneys believe that a disease must be curable in order for a physician's negligence to be compensated under the law.

The decision of the Trial Court and Appellate 3rd Circuit conflicts with the definition of causality by the Appellate 5th Circuit for the disease process Ankylosing Spondylitis.

> "He was diagnosed as suffering from Ankylosing Spondylitis, a chronic progressive and debilitating disease which fuses the spine and causes rigidity of the cervical, thoracic and lumbar vertebrae. "
>
> Smith v. U.S. Railroad Retirement Board 95-60433, 5th Circuit, U.S. Court of Appeals, Politz (Chief Judge), Davis, Emilio Garza
> The Appeals Court set forth the disease and cause.

3. A denial of pain and suffering claims would present a "Manifest Injustice" to incurable disease sufferers because Ankylosing Spondylitis is in the nature of a MINE claim. That is, "Medical Improvement Is Not Indicated". Since improvement is not indicated , the goal of medical practitioners is pain and suffering management and slowing disease progression. A late correct diagnosis would have important implications for alleviating current pain and suffering along with disease progression and considerable intrusion into the normal process of life.
SSA. DI 280 40.001 MINE Sec. 416.99c

A related question is whether or not the plaintiff's presentation to Dr. Mancall on 12-5-96 was so obvious that an ordinary person and not an expert would have recognized the spinal deformity; such that, an expert neurologist needn't be engaged.

Brophy v. Brizuela , 358 Pa. Super, 400, 405, 517 A. 2nd 1293, 1296 , 1986 . The Trial Court ignored testimonial evidence and medical records that were so obvious in physical deformity descriptions that an ordinary person could not possibly mistake the nature of the condition and its underlying characteristics or need for immediate treatment. A. 134

The Court is asked to review whether or not the Amicus Curiae brief submitted to the Appellate 3rd Circuit is admissible for purposes of validating the obvious nature of the plaintiff's condition during the month of 7/1996 a full 5 months prior to the patient's visit to Dr. Mancall MD. The brief sets forth the suspension of the head from the examination table while lying flat, stiffness of the head, shoulder, neck and spine, significant resistance in turning the head either left or right and an impression of ossification.

Appellate 3rd Circuit- Amicus Curiae Brief
Diplomate Charles Deng in Acupuncture

Diplomate Charles Deng testified on 5-4-04 at trial as to his diplomate status and the 7-6-1996 acupuncture encounter wherein he witnessed the musculoskeletal problems foundational to Ankylosing Spondylitis.

4. Discussion of Fed.Register 2-23-1998 P.8990; Writ 2,8

5. The Supreme Court is asked to determine whether the lower courts deliberated the factual basis of the case by reviewing all of the testimony in the expert witness presentation including: c/f A. 15, !6, A 23

- the expert's citation of Dr. Mancall's testimony
- the expert's citation of Dr. John R Waterman's testimony heard by video at trial on 5-5-04 and reproduced in transcript for the Appellate 3rd Circuit

A. 169

- Diplomate Charles Deng's physical presence and testimony at trial during the morning of 5-4-04 together with his Amicus Curiae brief to the Appellate Court 3rd Circuit
  Source: Diplomate Deng Trial Exam on 5-4-04 circa 11AM
  [Appellate Docket 22, 23 on A.26; DC 64 Limine Motion on the testimony of Diplomate Deng as expert appears to have no definitive ruling by the Trial Court on the docket.

The Supreme Court is asked to determine whether or not the Appellate 3rd Circuit erred in excluding the Amicus Curiae brief of Diplomate Deng for purposes of proving obviousness of the disease process in compliance with:
Brophy v. Brizuela and
Smith v. U.S. Retirement Board 95-60433 5th Circuit
Chief : Politz.

The trial testimony of Diplomate Felder MD expert in neurology is a multiple dependant trial examination. A.1-160 The testimony of Diplomate Felder MD multiply depends upon the trial testimony of Dr. John R Waterman MD-Rheumatologist and the physical phenomena witnessed by Diplomate Charles Deng, as well as the testimony of Dr. Elliot L Mancall MD-defendant and Diplomate Felder's interview of the plaintiff.

All of this testimony is in the 3rd Circuit Appellate appendix which would be argued if the Writ is granted. Excerpts are produced on A. 1 to A. 160 in the Writ Appendix created to provide a prelude to the full testimonies of the deponents at trial.

Rulings of the Trial Court:

The Petitioner requests that the Supreme Court consider over-ruling the Trial Court which removed significant evidential matter from the body of testimonial evidence and interfered with the ultimate comprehension of the case.

[Authority-Felder v. Casey]

A.124,125 A delineation of prior medical history describing important spinal range of motion issues brought by the Petitioner to the 12-5-96 encounter with Dr.Mancall. The Trial Court's ruling in favor of defendants concludes that Dr.Mancall did not have the relevant range of motion information available and he had this data. The Trial Court either forgot about this evidence or never entered it despite the fact that the exhibits were approved at trial. A.124-5

A99 -A100 Deposition of Diplomate Deng filed with the Trial Court and read into the Trial Exam of Diplomate Felder authenticates the Petitioner's claim that Dr.Mancall had the requisite range of motion data on hand and did nothing with it. [also see A.100 p. 42 ln. 4 to A.103]

A. 87 Diplomate Felder MD-Neurologist opined: "This is what I reviewed." consisting of the depositions of Dr.Mancall MD, Dr.Waterman MD-Rheumatologist, Diplomate Deng and an interview of the plaintiff. also c/f A135-43

A.103 / p.48 Diplomate Felder's expert testimony confirms that he does not see any quality control review at the Outpatient Clinic of Dr.Mancall in direct violation of the 2-23-98 Fed.Register Requirement for a Compliance Officer in Teaching Hospitals/Facilities. P. 8990

A.146-7 p.10 ln. 7-16 objections should be over-ruled to establish the necessity for early treatment for Ankylosing Spondylitis. see A147 ln.17-19

A154-5 Pg. 42 ln. 4-17 to A155 confirms Anky. Spon.

The Trial Court mis-apprehended the level of knowledge Dr.Mancall had about the case. It believed that the range of motion data was unavailable on 12-5-96; however, Diplomate Deng's testimony contradicts this materially and the patient brought Trial Exh. 124, 125 to the 12-5-96 exam. In effect, the patient did Dr.Mancall's work for him. It is the patient who is monitoring this case and not Dr.Mancall. A.1-14 (Trial Court opinion)

In addition, the Trial Court should have considered that the defendant may have destroyed records; such as the 8/1991 encounter form by Dr.Mancall at the Hahnemann Hospital. The medical student who took the Petitioner's medical history on 12-5-96 is not noted on the face of the TJUH encounter form and this omission is within Dr.Mancall's control. A.115-A117. The patient told Dr.Mancall that he was treating with Imitrex on memos Trial Exh.46-8 on A.120-123. Imitrex is about 9 times as expensive as Fiorinal . The drug which Dr.Mancall claims that he intended to prescribe. Why didn't Dr.Mancall object or call in the patient. A. 116 (Fiorinal noted on the TJUH encounter form)

The Trial Court mis-apprehended the inventory of facts relevant for consideration of the Rule 50 Motion as a Matter of Law. Dr.Felder's Trial Exam A. 83 onward is a multiple dependent Trial Exam. It is dependent upon the testimonies of Diplomate Deng-Acupuncturist, Dr.Waterman MD-Rheumatologist, the plaintiff and Dr.Mancall (defendant). The Trial Court considered only the Trial Exam of Diplomate Felder MD-Neurologist when the related testimonies cited above contained a wealth of facts about the disease process, treatment modalities and pain/suffering issues. Dr.Mancall's conduct is reviewable by the Medical Board of Penn.; the Office of Inspector General HHS and the Joint Commission on Accreditation of Hospitals headed by Commissioner Dr.Richard Frankenstein MD. These avenues of investigation are open to the Petitioner; however, a complaint in these venues would not yield the financial remuneration that a jury could provide.

Supreme Court, U.S.
FILED
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No. 05-1485

IN THE

Supreme Court of the United States

JOSEPH S. MARESCA,

Petitioner Pro Se,

v.

DR. ELLIOT L. MANCALL, MD and
THOMAS JEFFERSON UNIVERSITY HOSPITAL,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF IN OPPOSITION FOR RESPONDENT DR. ELLIOT L. MANCALL, MD

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COUNTERSTATEMENT OF THE QUESTIONS PRESENTED

1. Whether the District Court and the Court of Appeals for the Third Circuit erred by ruling/affirming the ruling that Petitioner Maresca failed to establish, through the required expert medical testimony, that Respondent Dr. Mancall breached the applicable standard of care or that said breach was the cause of, or a substantial factor in, bringing about Maresca's alleged injuries?

2. Whether the District Court properly applied the Federal Rules of Civil Procedure and Pennsylvania substantive law without error or omission, prejudicial or otherwise and Maresca had every full and fair opportunity to present his case and procure an expert opinion on standard of care and causation?

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B. The District Court did not err by granting judgment pursuant to Fed.R.Civ.P. 50 in that Maresca failed to establish that Dr. Mancall breached the standard of care or that said breach was the cause of, or a substantial factor in, bringing about his alleged injuries. 9

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C. The District Court properly applied the Federal Rules of Civil Procedure and Pennsylvania substantive law without error or omission, prejudicial or otherwise and Maresca had every full and fair opportunity to present his case and procure an expert opinion on standard of care and causation. 15

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STATEMENT OF THE CASE

This is a medical malpractice and corporate liability action initiated on September 7, 2001 by Petitioner, Pro Se Plaintiff Joseph Maresca, against Respondents, Defendants, Elliott L. Mancall, M.D. [hereinafter known as "Dr. Mancall") and Thomas Jefferson University Hospital (TJUH). Maresca alleges in his Complaint that Dr. Mancall failed to properly diagnose Maresca as suffering from ankylosing spondylitis during an office visit on December 5, 1996, or, to properly follow-up with Maresca thereafter.

A. Procedural History

Petitioner Maresca commenced this action by filing a Praecipe to Issue a Writ of Summons in the Court of Common Pleas of Philadelphia County. On October 29, 2001, this case was removed to the United States District Court for the Eastern District of Pennsylvania based on diversity jurisdiction. On or about February 13, 2002, Maresca filed a Complaint in the District Court. *See Maresca v. Mancall*, 2004 U.S. Dist. LEXIS 8658 (E.D. Pa., May 11, 2004). This matter was assigned to the Honorable Legrome D. Davis, Jr. Although Maresca's pleadings were far from clear, the District Court determined that Maresca had adequately pled a claim against Dr. Mancall for medical negligence, a claim against TJUH for corporate liability, and, a claim that TJUH was vicariously liable for Dr. Mancall's alleged negligence.

In the course of this litigation, the District Court issued an Amended Scheduling Order, ordering Maresca's Expert Discovery to be completed by November 18, 2002. Maresca provided two pre-trial reports from a neurologist, Mitchell S. Felder, M.D., his sole medical expert witness in this case.

Maresca also submitted Expert Letters, Submissions and Memorandum Describing Experts, Other Medical Providers and an Interrogatory of Dr. Abel, M.D. Maresca's Submission identified eight (8) potential experts: Dr. Mitchell Felder, neurologist; Charles Deng, acupuncturist; Dr. John Waterman, internal medicine and rheumatologist; Dr. Carter Abel, dermatologist; Dr. Kellman, internal medicine; Dr. Simon Lee, anatomy and cellular biologist; Dr. Majid Ali, pathologist; Dr. Alan Ebringer, cellular and bimolecular scientist. Both Defendants moved for summary judgment which the District Court denied by order of June 20, 2003, on the basis of Dr. Felder's written reports which were exchanged during discovery.

The final pre-trial conference was held on December 11, 2003. Thereafter, Dr. Mancall filed a Motion in Limine as to any expert other than Dr. Felder, inasmuch as none of Maresca's proposed experts could meet the requirements of the Federal Rules of Civil Procedure. The District Court granted Dr. Mancall's Motion in Limine on February 4, 2004[1].

At the second pre-trial conference and hearing on May 3, 2004, the Defendants presented argument on their respective Fed.R.Civ.P. 50 Motions. The District Court determined that they were premature because trial had not yet commenced.

At trial, Maresca presented Dr. Felder as his only medical expert witness. Dr. Felder testified via videotape deposition. At the close of Maresco's case, both Respondents, Thomas Jefferson University Hospital and Dr. Mancall renewed their

1. Maresca does not raise the issue of the grant of the Motion in Limine, on appeal. Even if he did, the District Court's ruling was in accordance with the facts and the law.

earlier Fed.R.Civ.P. 50 Motions for Judgment as a Matter of Law on the basis that Dr. Felder failed to provide expert medical testimony from which a jury could find that either Defendant breached a standard of care to Maresca, or that any alleged breach was the cause of any injury. The District Court held a lengthy two hour hearing on these motions on May 5, 2004, giving Maresca every opportunity to oppose the Defendants' motions[2]. By order of May 10, 2004, the District Court granted both Defendants' Motions for Judgment as a Matter of Law. *Maresca v. Mancall*, 2004 U.S. Dist. LEXIS 8658. The District Court further denied Maresca's Motion for reconsideration.

In its opinion, the District Court reasoned that Dr. Felder's testimony was insufficient to establish a deviation from the medical standard of care. *Id.* at *9. The District Court held that Dr. Felder's testimony failed to express the requisite degree of medical certainty, inasmuch as he testified that his opinion resulted from medical information not available to Dr. Mancall at the time of his diagnosis. *Id.*, at *8. The District Court further opined that nothing in Dr. Mancall's December 5, 1996 or Maresca's subsequent letters to Dr. Mancall indicated a history of complaint of progressive neck stiffness or pain by Maresca. *Id.* at *9. The District Court also noted that Dr. Felder testified that Dr. Mancall's request for an MRI and medication were appropriate, that the record indicated subsequent efforts by Dr. Mancall to follow up, and that the information available to Dr. Mancall would not suggest the need for a back examination. *Id.* at *9.

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2. The District Court cites to the Hearing notes, as well as Dr. Felder's testimony, in its opinion supporting its May 10, 2004 order and judgment. *See Maresca, supra*, at *3, *8,-*12, *15-*17,

The District Court also found that even if the testimony could be viewed as a deviation from the requisite standard of care, "the necessary showing of causation is wholly absent." *Id.* at *9. At no point did Dr. Felder assert that Dr. Mancall could have prevented or cured Maresca's condition had he discovered it earlier *Id.*, at *10. Rather, Dr. Felder acknowledged that there is no cure, definitive treatment or medication that can alter the natural progression of the disease. *Id.*, at *10. The District Court further held that even under a "substantial factor" test, Dr. Felder never articulated any difference in Maresca's ultimate prognosis that resulted from Dr. Mancall's alleged mis-diagnoses, nor did Dr. Felder identify any resulting injuries. *Id*, at *12. The District Court also stated that in response to its request to point to any instance in which Dr. Felder discussed causation, Maresca "instead read from treatises, pointed to exhibits not in evidence and conjectured about testimony he expected to elicit from defense witnesses." The Court also observed that even under a standard requiring a more relaxed degree of expert certainty, Dr. Felder's testimony was "critically deficient" to show that any care provided by Dr. Mancall was a factor in causing or increasing the risk of Maresca's injuries. Dr. Felder still never articulated any difference in Maresca's prognosis, or resulting injuries, from Dr. Mancall's alleged failure to diagnose Maresca on December 5, 1996.

The District Court also found that, inasmuch as Maresca filed to establish causation as to Dr. Mancall, the vicarious liability claim against TJUH must fail. Maresca also could not establish a corporate liability claim against TJUH because Dr. Felder never testified that TJUH breached a standard of care.

The Third Circuit affirmed the District Court by order and opinion of June 16, 2005. *Maresca v. Mancall*, 135 Fed. Appx. 529 (3d Cir. 2005). The Third Circuit Court agreed with the District Court that Dr. Felder did not testify within a reasonable degree of medical certainty that the Defendants breached the standard of care, or that any such alleged breach was the cause of the alleged injuries. The Third Circuit further held that Maresca's reliance upon Dr. Felder's report was misplaced, both in that the report did not provide sufficient evidence from which a jury could have found in Maresca's favor and in that the report was never admitted into the trial record and could not be considered as evidence by a jury. By order of December 19, 2005 the Third Circuit denied Maresca's Petition for Panel Rehearing. The Third Circuit also denied Maresca's Motion for Leave to File Exhibits in a Panel Rehearing in which Maresca attempted to supplement his appeal with matters not of record.

B. Factual Background

Petitioner Maresca's version of the facts of this case is incomplete and otherwise inaccurate. Maresca's Petition for Writ of Certiorari, like his Third Circuit Brief, contains frequent references to hearsay expert reports and testimony which is not of record[3]. Petitioner Maresca's only medical expert witness was Dr. Felder. Petitioner Maresca's Appendix contains documents and testimony not of record, which should not be considered by this Court.

This case concerns the medical treatment provided to Petitioner Maresca by Respondent Dr. Mancall. Dr. Mancall

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3. Maresca presented the testimony of Dr. Deng, an acupuncturist, but only as a fact witness.

examined Maresca on December 5, 1996. Dr. Mancall diagnosed Mancall with chronic headaches and prescribed muscle relaxants. Maresca alleges, however, that when Dr. Mancall examined him on December 5, 1996, Dr. Mancall should have identified Maresca's symptoms as corresponding to the medical condition ankylosing spondylitis, should have diagnosed this condition, and, that the alleged failure to diagnose this condition resulted in his continued suffering from and progression of this condition. Maresca maintains that he did not realize that he was suffering from ankylosing spondylitis until almost three (3)years later when he was diagnosed with the disease by a rheumatologist in September 1999.

Petitioner Maresca presented the testimony of only one medical expert, Dr. Felder. Dr. Felder's testimony is more notable for its omissions than its substance. Dr. Felder never offered any opinions that Respondent Dr. Mancall's alleged negligence caused any injuries to Petitioner Maresca. Dr. Felder never explained how Maresca's ultimate prognosis would have differed if Dr. Mancall had diagnosed him with ankylosing spondylitis on December 5, 1996, or what injuries Maresca allegedly suffered as a result of Dr. Mancall's alleged mis-diagnosis and failure to follow-up with the patient. Dr. Felder never asserted that Dr. Mancall could have cured Maresca's condition, had there been an earlier diagnosis. To the contrary, Dr. Felder acknowledged that there was no cure or definitive treatment for ankylosing spondylitis and there is no known medication that can alter the natural progression of the disease (A. 132). Also, Dr. Felder never stated that Maresca actually experienced any of these risks that he identified in his testimony, let alone that any such injuries resulted because Dr. Mancall did not diagnose Maresca's condition earlier.

Dr. Felder also retreated from, and clarified, his previous this testimony during cross-examination. On direct examination Dr. Felder testified that Maresca's symptoms, as reported to Dr. Felder by Maresca, should have been diagnosed as ankylosing spondylitis (A. 107, 108). On cross-examination Dr. Felder conceded however, that his opinion was based upon *medical information not available* to Dr. Mancall. (A. 126-129). Dr. Felder testified that he based his opinion upon Maresca's representation to Dr. Felder that Maresca demonstrated certain physical limitations to Dr. Mancall (R. 128). Based upon this information that Dr. Felder received from Maresca, Dr. Felder suggested additional examinations that Dr. Mancall could have performed, such as head movements or involving the spine, neck posture, pelvis and thigh rotation and testified that a doctor should respond to a patient's written correspondence. (A. 107-111, 118)

However, Dr. Felder acknowledged that nothing in Dr. Mancall's records or the subsequent letters from Maresca to Dr. Mancall, indicated a history of complaints of progressive neck stiffness or pain: they simply referred to "headaches" (A. 127-129). Dr. Felder conceded that, absent complaints of neck pain and stiffness, Dr. Mancall's diagnosis was appropriate. (A. 128).

Dr. Felder also testified that Dr. Mancall's request for an MRI and medication were appropriate, and agreed that Dr. Mancall made a recommendation for a plan of care (A. 126). Dr. Felder conceded that the record indicated subsequent efforts by Dr. Mancall to follow up with Maresca's care, and further, that the information available to Dr. Mancall would not suggest the need for a back examination (A. 128, 129).

REASONS FOR DENYING THE PETITION

A. Petitioner Maresca has failed to present any compelling reasons to grant review pursuant to Supreme Court Rule 10 or otherwise.

Petitioner Maresca has failed to present any considerations pursuant to which this Court should exercise its discretion to grant review, as set forth in Supreme Court Rule 10. Here the Third Circuit's decision affirming the District Court's grant of Defendants' Fed.R.Civ.P. 50 motions, is not in conflict with the decision of any other United States court of appeals on the same matter. The Third Circuit has not decided a federal question here at all, much less one in a way which conflicts with a decision by a state court of last resort. The Third Circuit has neither departed from the accepted and usual course of judicial proceedings, nor has it sanctioned any such departure by the District Court. Additionally, the Third Circuit has not decided an important question of federal law which has not been, but should be, settled by this Court, nor has it decided an important federal question in a way that conflicts with relevant decisions of this Court.

Here the asserted errors are fact and case specific and relate solely to the District Court's assessment of whether the Petitioner Maresca's sole medical expert witness Dr. Felder testified within a reasonable degree of medical certainty that the Defendants breached a standard of care or that said breach was the cause of the Maresca's injuries, such that the case could be presented to a jury.

B. The District Court did not err by granting judgment pursuant to Fed.R.Civ.P. 50 in that Maresca failed to establish that Dr. Mancall breached the standard of care or that said breach was the cause of, or a substantial factor in, bringing about his alleged injuries.

The District Court properly granted judgment as a matter of law in favor of Dr. Mancall at the close of Maresca's case, because Maresca could not state a prima facie case against Dr. Mancall on any of his claims. The testimony of Maresca's sole medical expert, Dr. Felder failed to satisfy Maresca's burden of proving with expert medical testimony within a reasonable degree of medical certainty, that Dr. Mancall breached the requisite standard of care or that Dr. Mancall's alleged breach caused any injury to Maresca.

In order to present a prima facie case of medical malpractice, Maresca was required to prove: (1) The standard of care for the health care providers in defendant's position, at the time of the injury, under the same or similar circumstances, in treating a patient exhibiting the same symptoms as the plaintiff; (2) That the care accorded to the plaintiff by any defendant failed to meet the standard of care applicable in that time period; (3) That the specific failure to comply with the standard of care was a substantial factor in the cause of the injuries complained of by the plaintiff; and; (4) That the plaintiff's injuries were the result of the failed conduct. *Lambert v. Soltis*, 221 A.2d 173 (Pa. 1966); *Demchuk v. Bralow*, 170 A.2d 868 (Pa. 1961). The plaintiff is required to "offer an expert witness who will testify 'to a reasonable degree of medical certainty, that the acts of the physician deviated from good and acceptable medical standards, and that such deviation was the proximate cause

of the harm suffered.'" *Eaddy v. Hamaty*, 694 A.2d 639, 642 (Pa. Super. 1997) (*quoting Mitzelfelt v. Kamrin*, 549 A.2d 935 (Pa. Super 1988)).

A correct interpretation of Pennsylvania substantive law was applied by both the District Court and Third Circuit. Here Dr. Felder's testimony was simply insufficient to satisfy either prong of the requisite analysis.

First, Dr. Felder never testified within a reasonable degree of medical certainty that Dr. Mancall caused any injury to Maresca as required by Pennsylvania substantive law. *See Hoffman v. Brandywine Hosp.*, 661 A.2d 397, 402 (Pa. Super. 1995). An expert opinion based upon mere possibilities, guesswork or conjecture is not competent evidence. *Al Hamilton Contracting Co. v. Department of Envtl. Resources*, 659 A.2d 31, 36 (Pa. Cmwlth. 1995); *Childers v. Power Line Equip. Rentals, Inc.*, 681 A.2d 201, 209 (1996), *allocatur denied*, 690 A.2d 236 (Pa. 1997). "An expert fails this standard of certainty if he testifies that the alleged cause 'possibly,' or 'could have' led to the result, that it 'could very properly account' for the result, or even that it was 'very highly probable' that it caused the result." *Hoffman* at 402 (*quoting Kravinsky v. Glover*, 396 A.2d 1349, 1356 (Pa. Super. 1979)). While the expert need not testify with absolute certainty or rule out all conceivable causes of the plaintiff's condition, the expert does not state with a reasonable degree of certainty that the plaintiff's injuries occurred because of the negligence of any of the defendants, then plaintiff has failed to establish a prima facie case. *Mitzelfelt, supra*; *Kravinsky v. Glover*, 396 A.2d 1349 (Pa. Super. 1979).

Maresca cites no support for his contention that ankylosing spondylitis sufferers were not adequately protected under Pennsylvania law by reason of the District Court's decision. Moreover, the District Court did apply Pennsylvania substantive law as set forth in *Mitzelfelt*, *supra*, and other decisions, by analyzing Maresca's evidence under the less stringent standard of "substantial factor."

Maresca also cites no authorities in support of his argument that the concept of causation is "irrelevant" in an ankylosing spondylitis case because it is incurable or that Pennsylvania substantive law was interpreted in any way at odds with itself or federal law, if indeed any federal law was applicable here. Maresca does not cite any authorities for the proposition that his federal rights were abridged by 'local practice" in applying substantive Pennsylvania law on medical malpractice. Nothing in the District Court or Third Circuit's opinions suggest that either court has confused the concept of causing ankylosing spondylitis per se, with causing injury, pain or suffering from ankylosing spondylitis. Maresca cites no authorities for his proposition that expert medical testimony was not required here. Moreover, any alleged discrepancies among the "federal" and "state" definitions of ankylosing spondylitis are completely irrelevant. The applicable law was not ambiguous nor was it erroneously applied.

Here there was simply no unequivocal medical expert testimony attributing any injuries to an alleged late diagnosis of ankylosing spondylitis. Dr. Felder never testified that Maresca suffered any injuries or pain as a result of Dr. Mancall's alleged negligence. Dr. Felder never explained how Mr. Maresca's ultimate prognosis would have differed if Dr. Mancall had diagnosed him with ankylosing spondylitis on

December 5, 1996, or what injuries Mr. Maresca allegedly suffered as a result of Dr. Mancall's alleged mis-diagnosis and failure to follow-up with the patient. Dr. Felder never asserted that Dr. Mancall could have cured Maresca's condition, had there been an earlier diagnosis. To the contrary, Dr. Felder acknowledged that there is no cure or definitive treatment for ankylosing spondylitis and there is no known medication that can alter the natural progression of the disease (A. 132)

Maresca likewise could not set forth a prima facie case of medical malpractice under the "substantial factor" test, which the District Court did consider. Dr. Felder did not identify any injuries to Maresca caused by Dr. Mancall. While Dr. Felder opined that Maresca was at risk for certain life-threatening ailments, such as systemic vascular degeneration, during the period between December 5, 1996, and September 15, 1999, when Maresca was diagnosed as having ankylosing spondylitis, Dr. Felder never stated that Maresca actually experienced any of these risks, let alone that any such injuries resulted because Dr. Mancall failed to diagnose Maresca's condition earlier (A. 120, 121). Again, Dr. Felder also never explained how Maresca's ultimate prognosis would have differed with an earlier diagnosis. Dr. Felder's reference to a Crohn's disease exacerbation was not connected to any failure to diagnose by Dr. Mancall.

While Maresca repeatedly references Dr. Felder's expert report in his Petition, as he did below, this report was never entered into the trial record, thus is hearsay. Additionally, Maresca never asked Dr. Felder about the contents of his report regarding causation, during Dr. Felder's videotape deposition. Dr. Felder did not address causation in his trial deposition testimony, nor was he asked to. The only time Dr.

Felder affirmed the contents of his report, was when he confirmed that if there were no complaints of neck pain and stiffness made to Dr. Mancall, there would be no consideration or indication of ankylosing spondylitis (A. 131). Dr. Felder did not link Dr. Mancall's alleged negligence and Mr. Maresca's alleged injuries, let alone provide such testimony with the requisite degree of medical certainty.

Maresca also could not establish causation through other hearsay and "exhibits" not in evidence, medical treatises, or, testimony that he "expected" to elicit from Defendants' witnesses. Notably, although Maresca frequently cites to fact witness Dr. Deng's testimony, Dr. Deng was not Maresca's medical expert witness, Dr. Felder was, thus the District Court had every right to disregard Dr. Deng's testimony in determining whether Maresca presented a prima facie case.

Second, Dr. Felder's testimony could not establish a deviation from the standard of care for many reasons, including the fact that he never asserted that Dr. Mancall could have cured Maresca's condition had there been an earlier diagnosis. To the contrary, Dr. Felder acknowledged that his opinion was based upon medical information not available to Dr. Mancall at the time of the examination that there is no cure or definitive treatment for ankylosing spondylitis, and, there is no known medication that can alter the natural progression of the disease. (A. 126-129)

Dr. Felder also testified that he based his opinion upon Maresca's representation that Maresca demonstrated certain physical limitations to Dr. Mancall (R. 128). Significantly, Dr. Felder acknowledged that nothing in Dr. Mancall's

records or the subsequent letters from Maresca indicated a complaint of progressive neck stiffness or pain: they simply referred to "headaches" (A. 127-129). Dr. Felder explicitly testified that if there were *no complaints* of neck pain and stiffness made to Dr. Mancall, there would be *no consideration* or indication of ankylosing spondylitis and Dr. Mancall's diagnosis was appropriate (A. 128, 131).

Maresca also could not establish a deviation from the standard of care because Dr. Felder testified that Dr. Mancall's request for an MRI and medication were appropriate, and agreed that Dr. Mancall made a recommendation for a plan of care (A. 126). Dr. Felder conceded that the record indicated subsequent efforts by Dr. Mancall to follow up with Maresca's care, and further, that the information available to Dr. Mancall would not suggest the need for a back examination (A. 128), 129).

As set forth above, Maresca was plainly not entitled to have his case heard by a jury. Therefore, the District Court properly entered judgment as a matter of law in favor of Dr. Mancall pursuant to Fed.R.Civ. P. 50.

C. The District Court properly applied the Federal Rules of Civil Procedure and Pennsylvania substantive law without error or omission, prejudicial or otherwise and Maresca had every full and fair opportunity to present his case and procure an expert opinion on standard of care and causation.

In addition to properly applying Pennsylvania substantive law, the District Court did not overstep its bounds procedurally or otherwise abridge Maresca's due process rights. The District Court supplied an exacting analysis of the inadequacy of the evidence of record and explained its conclusions regarding the lack of evidence at length, with numerous citations to the testimony of Dr. Felder and the motion hearing record. It was Maresca who clearly failed to present sufficient medical expert testimony on the issue of causation to state a prima facie case for medical malpractice against Dr. Mancall. If the plaintiff's expert cannot form an opinion with sufficient certainty so as to make a professional judgment, there is nothing on the record from which a jury can make a legal judgment with sufficient certainty. *Kravinsky*, 396 A.2d at 1356.

Maresca cannot show any material errors or omissions, relevant or otherwise, regarding the District Court's conduct, the record, the evidence or the District Court dockets that would have any impact on the District Court's decision, prejudicial to Maresca, or otherwise. Maresca had every full and fair opportunity to present his case and procure an expert opinion on standard of care and causation. The District Court had no obligation to '"reserve judgment" and hear both sides of the case before granting judgment for the Defendants pursuant to Fed.R.Civ. P. 50, and indeed applied the proper sufficiency of the evidence analysis for such motions.

Maresca also cites no support for his proposition that application of the "reasonable person standard" at the close of his case was procedurally or legally incorrect.

The other arguments advanced by Maresca defy comprehension and cannot be addressed, even if they had not been waived below.

CONCLUSION

For the foregoing reasons, Respondent Dr. Elliot L. Mancall, MD respectfully requests that the Petition for A Writ of Certiorari file by the Petitioner-Plaintiff Maresca, be denied.

Respectfully submitted,

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Joseph S. Maresca — Petitioner Pro-Se

versus

Dr.Elliot L Mancall MD — Respondents
Thomas Jefferson University Hospital

Petitioner's Reply to Respondents
On Petition for a Writ of Certiorari-Filed 3-16-06

To Court of Appeals 3rd Circuit: 04-3103
(Rendell, Fuentes, Opinion by Garth)

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1. The questions presented by the Respondent Reply are too narrow. The Petitioner properly asks the Supreme Court to consider (Q1) the 323(a) Restatement of Torts at EADDY 694 as the governing precedent at the close of Petitioner's Case in Chief because the weight of the testimonies of the Plaintiff, Diplomate Deng, Dr.Waterman-Rheumatologist, Dr. Kellman -Internist, Dr.Lee- Physiatrist, PhD and Dr. Felder-Neurologist/Psychiatrist-Expert set forth the risks of untreated ankylosing spondylitis A134 and the context of the patient's overall condition such that a reasonable person could determine a connection between the physician's breach, the increased risk of harm & the conclusion that sufficient evidence exists to overcome a motion for judgment as a matter of law. Book II A28-A172 Petitioner's (Q2) asks the Court to examine the contrast between the federal law MINE-SSA DI 280, 40.001 and the 5th Circuit 95-60433 Ankylosing Spondylitis case which sets forth the obvious nature of the spinal deformities. MINE-SSA DI 280 defines ankylosing spondylitis as a disease process where "Medical Improvement Is Not Indicated" thereby rendering irrelevant the concept of causality of the disease process. Besides, nowhere does the Pennsylvania statute require a connection between the physician's negligence and causality of the disease. The connection in this case is between the physician's negligence and the lack of treatment leading to incremental pain and suffering in the intervening period 12-5-96 and 9/ 1999. (Q3) deals with a Manifest Injustice to sufferers of Ankylosing Spondylitis, later in life Tay Sachs, later in life Sickle Cell Anemia and Myasthenia Gravis. These are all incurable but treatable diseases. The Petitioner is alive and treating his ankylosing spondylitis a full 10 years after the onset of the disease by the testimony of Diplomate Felder and Diplomate Epstein - the defense expert. A 164

(Q4) by the Petitioner sets forth Fed. Register Vol 63#35 issued 2-23-1998 P. 8990 which requires teaching facilities; such as Dr.Mancall's Outpatient Medical School Clinic, to engage a compliance officer by statute. Judging from the timeline of this legal requirement, Petitioner's claims will have been halved if a compliance officer had reviewed Dr.Mancall's patient file, noted the deficiencies and contacted the patients for the monitoring never done by Dr.Mancall. (Q5) deals specifically with substantial juridical deficiencies noted on A15,16 and A23. It is to be noted that the Honorable Legrome Davis issued an 8-30-2004 second order dismissing the lawsuit WITHOUT PREJUDICE and indicating that the matter was in the Appellate 3rd Circuit and too late for him to act any further. In addition, the Petitioner's questions ask the Supreme Court to distinguish between undefined OBVIOUSNESS criteria in the Pennsylvania law; namely, Brophy v. Brizuela 358 Pa. Super 400, 405, 517 A 2nd , 1293, 1296 (1986) and UNOBVIOUSNESS criteria in Metzelfelt v. Kamrin 526 Pa. , 54 62, 584 A 2nd 888,89 (1990). In addition, neither precedents bar fact witness testimony from consideration or from incorporation into the overall testimony of the expert under Metzelfelt criterion. The Pennsylvania law states that either Brophy v. Brizuela OBVIOUSNESS criteria or Metzelfelt UNOBVIOUSNESS criteria may be chosen; however, both criteria cannot be considered concurrently. In addition, the Respondents have omitted the Petitioner's 1st, 7th, 14th and 21st amendment rights which are argued extensively in the "Cited Authorities" of pp. x- xiii of Petitioner's Writ. The Petitioner's most recent prognosis is total destruction of the sacroiliac & pelvic joints reported in the 3rd Circuit Court of Appeals. [A96 p. 33 ln.1 to A97 sacroiliac joint x-ray deficiency] The Respondents' Brief in Opposition to the Petitioner's Writ fails in a number of other areas; namely,

2. The Court, in its 8-30-04 DENIAL, indicated that it was too late to consider the case further and the Petitioner had to continue the appeals process with the 3rd Circuit. The District Court changed its original DENIAL from with prejudice to WITHOUT PREJUDICE. A.1.

3. The Petitioner's ultimate prognosis is irrelevant by the MINE-SSA DI 280 40.001 which considers ankylosing spondylitis incurable so that the focus moves to treating symptoms and not a cure. Diplomate Felder testified " Its treatment of symptomatology." A. 113 p. 110 ln. 20

4. Diplomate Felder testified conclusively that the Petitioner had ankylosing spondylitis on 12-5-96. A. 88 ln. 12 to A. 114

5. Diplomate Felder did not change his opinion based upon the cross-exam of Bradley Goewert, Esq.
" I would say I still hold those conclusions."
A. 113 P. 115 ln 3. If anything, Diplomate Felder returned back to his original conclusions because Diplomate Deng independently confirmed the Petitioner's range of motion issues a full 6 months prior to Dr.Mancall's 12-5-96 exam.

6. Dr. Mancall had in his possession a memo brought by the Petitioner describing an inability to do a sit-up or run-all pertinent to bone/range of motion issues. Dr.Mancall testified that he read this memo. A. 114; A. 52 pg. 46-7 ln. 15
The Respondents are in error on the matter of Dr.Mancall's witnessing the range of motion issues during the 12-5-96 exam. Also, respondents did not object to the Defendant's admission made part of Dipl.Felder's Trial Examination.

7. Dr. Mancall dissuaded the Petitioner from considering spinal issues when he told the Petitioner "No.No. Don't touch the spine." A. 32 (Trial Exam of the Plaintiff/Petitioner)

8. The Petitioner read Diplomate Felder verbatim from Diplomate Deng's Deposition regarding range of motion issues at the 7-6-96 exam (5 months prior to Dr.Mancall's exam). Essentially, Diplomate Deng opined on all the range of motion issues present on 7-6-96 which never changed subsequently. A. 100 to A 103. The Honorable Judge Davis apparently agrees with the Petitioner because the 8-30-04 dismissal was changed from "prejudice" to a "without prejudice" dismissal of the case.

9. The Petitioner's claim was filed first in the Court of Common Pleas in Philadelphia. The case was moved by the TJUH attorneys due to "diversity" jurisdiction. In reality, these cases are moved from the Court of Common Pleas to the Federal Jurisdiction because federal juries are chosen statewide and the Court of Common Pleas has jurors from the Philadelphia area. These Philadelphia area jurors tend to award Plaintiffs more money than the Federal juries. The Petitioner obtained an 11-22-02 expert letter from Diplomate Felder MD Neurologist and Psychiatrist. The letter opined on the lack of a diagnosis, monitoring and treatment. Diplomate Felder MD discussed all sorts of diagnostic modalities, treatment modalities and linked Dr. Mancall MD directly to the non-diagnosis, non-treatment and incremental pain and suffering. A135 to A 143

Ms. Holly Sands, Esq. of Marshall, Dennehy was assigned the task of obtaining expert letters for the defense. In obtaining these expert letters, the testimony (A28-39) and original deposition of Diplomate Deng was never presented to the defense experts. The Petitioner's memo to Dr. Mancall MD taken to the 12-5-96 encounter was omitted from consideration by the defense experts. Naturally, the defense experts concluded that Dr. Mancall MD performed an examination in accordance with generally recognized standards of medical practice.

Ms. Holly Sands, Esq. left the firm without communicating her exit to the Petitioner. A161 to A165. This very aggressive defense of the defendant by Marshall, Dennehy may not comply with the Commissioner of Insurance for the State of Pennsylvania. The Commissioner's Office expressed concerns that meritorious cases are paid rather than defended with marginal legal tactics. The Petitioner was offered the opportunity to have an insurance investigator placed on the case; however, the Petitioner declined to do so until the underlying litigation concludes.

10. The Petitioner had obtained his medical record from the TJUH, Inc. institutional medical records early in 2001 prior to commencing this lawsuit. The medical record consisted of the 12-5-96 encounter form of Dr. Mancall MD, 3 letters written to Dr.Mancall MD by the Petitioner subsequent to the 12-5-96 encounter, a typed memo brought to the 12-5-96 encounter (describing the inability to do a sit-up and run) and a 12/1991 blood test from the 8/1991 visit to Dr.Mancall at the Hahnemann Hospital. A115-116, A117- A125; A113 p.85

11. At the 7-24-02 deposition of Dr.Mancall MD-Neurologist and Defendant, only the Thomas Jefferson University Hospital encounter form was offered as the medical record.
Either the doctor or a staff member had accidentally or willfully destroyed the remainder of the medical record secured by the Petitioner much earlier in 2001. The Petitioner secured the entire medical record by requesting the TJUH, Inc. medical records facility to produce copies prior to commencing the lawsuit. At the 7-24-02 deposition of Dr. Mancall MD, the plaintiff produced date-stamped copies of his letters to Dr. Mancall MD and the letter brought to the 12-5-96 examination by the plaintiff. When these letters were produced by the plaintiff,

the defendant's attorney, Ms. Cynthia Brennan, Esq. placed her head in hand because the hospital was prepared to admit the encounter form only. As with Ms. Holly Sands, Esq., Ms. Cynthia Brennan, Esq. left the litigation shortly after this deposition and was never seen or heard from again.

12. The trial record at the District Court commenced 5-3-04 with the Plaintiff testifying on 5-3-04. Diplomate Deng, (A28-39) Acupuncturist testified in person on 5-4-04. A videographer set up equipment in the District Court in order to run video presentations of Dr. Waterman MD-Rheumatologist, A57-71; Dr. Raphael Kellman MD-Internist A72-82 & Diplomate Felder MD-Neurologist, . A83-143

These presentations ran 5-4-04 through the morning of 5-5-04. Following the videos, selected excerpts of Dr. Lee MD, PhD were read into the record by the Plaintiff, Messrs. Goewert, Esq. and Dorothy Duffy, Esq. for the defendants. A144 to A 160

13. Afterward, the Petitioner cited an exhaustive group of Exhibits ; wherein, the Court pronounced its concurrence into the record as evidentiary matter to be considered by the District Court and jury.

{ A115-128; A39-43; A67-69; A79-83; A66-71; A156-160; A129-130; A135-143; A133; A55-56; A131-2 }

The District Court noted the conclusion of Plaintiff/Petitioner's Case in Chief and the Civil Rule 50 argument was invoked.

14. The matter of the Supreme Court review will involve the sufficiency of the totality of the Plaintiff's Case in Chief Presentation as to obviousness criteria in the law, unobviousness criteria in the law and Eaddy at 694 criteria as well as whether or not the District Court employed good juridical practices including the "reserve of judgment" until completion of the Defense Cases in Chief. The Petitioner's 1st, 7th, 11th, 14th and 21st amendment rights are before the Supreme Court for review together with the Federal Register Vol 63 #35 issue 2-23-1998 P.8990 which requires a "Compliance Officer" in medical school facilities/institutions. DC Docket 26 & 30(DENIED). A 166-A172.

15. The medical record of Dr.Mancall MD-Neurologist is before the United States Supreme Court. A115-A116. The top portion of the medical record was prepared by an unknown medical student. The pain and suffering of the Petitioner is causally connected to Dr.Mancall's examination and medical encounter form of the TJUH. The worsening of the pain after typing on the computer is causally connected to the workplace. There is a partially implemented plan with no followup. A116 " Plan MRI, If Okay. Fiorinal, return post-MRI. "

16. A Brain-MRI was returned to Dr.Mancall citing cerebellar atrophy which is nowhere on the encounter form. Dr.Mancall MD-Neurologist has come to no conclusion about whether or not this cerebellar atrophy is problematic. The risks of untreated ankylosing spondylitis were noted by Petitioner's expert Dr. Felder MD-Neurologist, Psychiatrist A134, A111-114. The professional literature citation on A134 mentions cerebrovascular disease as a prominent risk of untreated ankylosing spondylitis. A115 to A119

17.. On February 13, 1997, the Plaintiff/Petitioner wrote Dr. Mancall MD reporting that Imitrex 25 mg. was being taken. On A120 and A121, the cost of this medication is reported over $10.00 per pill. The Fiorinal drug listed above is slightly over $1. per pill and Dr.Mancall is not objecting to the Plaintiff/Petitioner taking a pill that is nearly 10 times more expensive than Fiorinal. For this reason alone, the Petitioner believes that Dr.Mancall MD prepared the encounter form some time after 12-5-96 and that the preparation of the encounter form could be in the nature of a fraud in de factum. A49 ln. 23 ; A50

In addition, it's the Petitioner who is following up on the case by writing 3 unanswered letters to Dr.Mancall MD. There are no notations about monitoring on the face of the Thomas Jefferson University Hospital encounter form. A. 115, 116. In addition, Dr.Mancall dissuaded the Petitioner from a spinal diagnosis. A. 28- A. 32 For this reason, Petitioner's subsequent memos to Dr.Mancall do not mention the spine again. In effect, Dr.Mancall succeeded in de-railing a correct diagnostic impression by Diplomate Deng. A.33 to A.39 Dr.Mancall did double damage. He made a mis-diagnosis and dissuaded the Petitioner from a correct diagnostic impression by Dipl.Deng.

18. On September 30, '96, a full 2 months prior to the visit to Dr. Mancall MD- the Health Insurance Portability and Accountability Act of 1996 PL104-191 was put into effect. It requires the Secretary of HHS to adopt security standards and establish policies and procedures to prevent unauthorized access to data. Those persons who maintain and transmit health care data must apply reasonable and appropriate administrative, technical and physical standards to ensure the integrity of medical information.

Federal Register Vol 63 #35 issue 2-23-1998 P.8990 requires a "Compliance Officer" in medical school facilities/institutions. The Secretary of HHS has designated the OIG to enforce the provisions of this part.

19. The Pennsylvania Medical Board has disciplinary discretion over all physician registrants in the State of Pennsylvania. The Joint Commission on Hospital Accreditation , Commissioner Richard Frankenstein MD, has authority to review hospital standards. These avenues are open to patients generally; however, only the District Court or the Court of Common Pleas can referee a proceeding that awards financial damages for pain & suffering, financial loss & non-monitoring/mis-diagnosis.

20. Another problem with referring Dr.Mancall's deposition, encounter form of TJUH and the Petitioner's memos written to Dr.Mancall involves the plenary jurisdiction of the Board of Medicine over Dr.Mancall. Once these matters have been referred, the Petitioner can't ask that the investigation be dropped if Dr.Mancall's insurers decide to pay the case. If Dr. Mancall has destroyed any of the evidence or withheld the medical student witness from testifying, the Petitioner cannot insulate Dr.Mancall from criminal liability. For these reasons, together with the 11-22-02 expert letter, the Petitioner & Court tried to prevail upon the insurers to pay a reasonable settlement on the case. The Board of Medicine in the State of Pennsylvania has the authority to referee a Professional Malpractice Trial of the Respondents in this case.

22. Petitioner's Objections to Respondents' questions on facts not in evidence: (1-16-04 Trial Exam of Dipl.Felder) Appellate Court Appendix Pages : A 126- A. 131

p. 88 ln. 4-12; p. 90 ln. 1-16; p. 94 ln. 7-16

p. 100 ln. 13 Petitioner's reference to Diplomate Deng's testimony on range of motion issues

p. 108 Petitioner's reference to documented complaint of inability to do a sit-up or run ln. 4; p. 109 ln. 15-16

23. This case is about the Petitioner's misplaced trust in Dr. Mançall MD-Neurologist/Surgeon since 1959, as well as, the TJUH, Inc. medical school staff. The last place a member of the public would expect a mis-diagnosis is a medical school. The academic rigors and environment of such an institution should be well beyond reproach in every respect. Today's artificial intelligence software will produce a diagnosis even without a physician. Dr.Mancall was assisted by a medical student albeit an unknown one. The Petitioner forwarded Ms. Cynthia Brennan, Esq. a potential list of medical students who could have taken the history on 12-5-96. These names included William Wong and Michael Oh. Shortly afterward, Ms. Cynthia Brennan, Esq. was never heard from ever again. Contrary to Mr. Goewert's highly improper questioning, Dr. Mancall admitted to reading the memo brought by the Petitioner to the 12-5-96 examination. Book II- A. 52 ln. 16; A53, A54, A125 Diplomate Deng confirmed all of the gross range of motion spinal symptomatology in Book II A. 33 to A. 39. This confirmation was a full 5 months prior to Dr.Mancall's exam. Dr.Raphael Kellman MD-Internist confirmed 9-15-99 as the date which the Petitioner would have been first told of the disease ankylosing spondylitis. Book II- A. 77. The three year period of a non-diagnosis is confirmed by independent fact witnesses including Dr. Waterman MD-Rheumatologist. A59 to A71 with emphasis on A. 68 to confirm 9-15-99 as the date the Petitioner would have been informed of the disease Ankylosing Spondylitis by Dr.Waterman MD. " I spoke with Mr.Maresca today (9-15-99). " A. 68

The Petitioner should be compensated reasonably for the period of non-diagnosis, non-treatment and the interminable strife of a litigation through the DC, 3rd Circuit Appellate and United States Supreme Court. The Petitioner was forced to spend monies that could have been earmarked for treatment because Dr.Mancall consciously gave plausibly deniable testimony instead of admitting his errors and paying the case so that the parties could have returned to normalcy.

(5)

Supreme Court, U.S.
FILED
OCT 26 2006
OFFICE OF THE CLERK

No. 05-1485

Supreme Court of the United States
1st Street N.E. DC 20543 -Clerk Office
202-479-3011

Joseph S. Maresca — Petitioner Pro-Se

versus

Dr.Elliot L Mancall MD — Respondents
Thomas Jefferson University Hospital

On Petition for a REHEARING under Rule 44
Petition for Certiorari denied 10-12-06
Due 10-27-06 within 25 days

To Court of Appeals 3rd Circuit: 04-3103

Joseph S. Maresca-Pro-Se — PETITIONER-PRO-SE
of Record
Bronxville, NY 10708-0646
914-482-7095

Submissions to Date: Writ of Certiorari-Book I,
Appendix-Book II, Petitioner's Reply to the Respondents,
Rule 44 Petition for a Rehearing

Marshall, Dennehy et al.
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REHEARING BRIEF -MEDICAL MALPRACTICE CASE
5 QUESTIONS PREVIOUSLY PRESENTED IN THE
BOOK I OF THE PETITIONER

Controlling Effect Implications and Other Substantial Grounds Not Previously Presented:

1. An award for Dr.Mancall just preceding trial may present a conflict of interest because it places him in competition with his own neurologist expert and the plaintiff expert. The Journal of the American Board of Psychiatry and Neurology reports the following in the Winter '04 ABPN:

Elliot L. Mancall MD- Received the 2003 Presidential Medal from the American Academy of Neurology for serving as founding editor of Continuum and for continuous editorial service from 1994 to 2003.

It is an award of the President of the American Academy of Neurology. Did Dr.Mancall or his institution of TJU disclose the existence of this lawsuit to the award body? Why or why not? Did this award detract from Dr.Mancall's insurer paying this case before trial. If the award body knew of the existence of this lawsuit, would they have granted the Presidential Award to Dr. Mancall at that time? Does the award just before trial interject politics into the Trial Court? Is this award the reason why the District Court and Appellate Court do not cite huge volumes of testimony from Diplomate Deng-Acupuncturist, Dr. Waterman-Rheumatologist, Dr. Simon Lee, Physiatrist and PhD in Cellular Biology and Dr. Kellman MD-Internist? Videos of Drs. Waterman-Rheumatologist, Kellman-Internist were shown in the District Court from the afternoon of 5-4-04 through the morning of 5-5-04. [2 half day video sessions in the DC by Spherion]

Diplomate Deng was sworn in at trial on 5-4-04.
Only the expert video of Diplomate Felder MD is cited.
A.1 to A14; A19-A.24
This testimony and the supporting exhibits in Book II prove that the Plaintiff's Case in Chief is "wholly supported" by the facts and within the reasonable person standard at the close of the Plaintiff's Case in Chief. There is absolutely no grey area in the gross range of spinal motion issues opined by Diplomate Deng and Dr. Waterman-Rheumatologist.
[A33-A39] [A57-A71]
The controlling effect is that all medical deponents at trial are placed in an awkward position between an award decision of the medical profession , the evidence of the case and the political calculus accompanying a "Presidential Award" . According to Associate Justice Sandra Day O'Connor, "the Courts are not a political body". The Supreme Court is asked to weigh whether or not the Petitioner's "Due Process" rights have been marginalized. Admitted facts wholly supporting the case are contained in Book I- page v (APPROVED EVIDENCE)

2. Diplomate Deng's testimony as to gross range of motion is outside the scintilla of evidence and grey area. It is irrefutable testimony unchallenged by Bradley Goewert,Esq. counsel for the defense. The controlling effect is that this evidence governs and completely satisfies the BROPHY standard which requires that the patient's presentation must be obvious to an ordinary person and that the need for medical treatment must also be obvious from a common sense point. Diplomate Deng explained that his acupuncture examination showed very limited spinal mobility, limited ability to ambulate, redness of the face, sweating, pain and stiffness of the neck and shoulder.

" And after I check up with him, I found he has a limitation of mobility of the spine, and the neck and the lower back. It's really limited on his vertical area. He can only turn his neck on the left side 5 degrees or so, 10 degrees on the right, and almost--almost cannot sit down by himself." A.37

In addition, the patient's head protruded upward from the exam table; such that, it did not lie flat.
Q. Diplomate Deng, did you ever at any time have the patient lying flat on the examination table?
A. Yes. I did.
Q. And in the patient lying flat on the examination table did you notice anything in particular?
A. His head couldn't touch on the back flatly like the other -like normal people lie down. So I have to put--double up the pillow under his neck to support the head.
Q. Is it your testimony that you had to put a double pillow under the plaintiff's head to support his head so that it could rest comfortably, is that your testimony?
A. Yes
Q. And Diplomate Deng did that condition ever change?
A. No

Source: Book II A. 37, 38, Allowed Evidence A. 39 Trial Exhibit 12 : COURTROOM DEPUTY-Marcella El Shabazz
Transcribed by Drummond of Haddon Hts.,NJ
Swearing In of Diplomate Deng- A. 34

Full Transcript by Rita A. Doughterty 2-28-05
Appellate 3rd Circuit APP. 359-APP. 382

This testimony wholly supports the Petitioner's testimony at trial A. 28- A.32 The Petitioner described his 12-5-96 exam by Dr. Mancall MD-Neurologist and his medical student assistant (approximately 5 months subsequent to Diplomate Deng's Exam)

" At some point, I brought up about the spine and he walked over maybe to the wall. And when I brought up the spine, it was almost like a holdup. He put his hands in the air and he said:
'No, no don't touch the spine.'
' He said it like in a whine, and I really didn't question it beyond that. I know there was a little discussion about the spine. He may have theorized about gravity...'" Book II-A32

Diplomate Deng's testimony is subsequently wholly supported by the facts of Dr.Waterman's exam at the UCONN Medical School and subsequent x-rays and comparison x-rays. The gross range of motion of the head/neck is wholly supported by Dr. Waterman's finding of Ankylosing Spondylitis. Book II. A. 63,64

Q. Did you move the patient's head up and down.
A. Yes, As I said, he had decreased cervical range of motion in all directions, so up, down and sideways, right, left. (Excerpts : Book II- A.64 ln. 13)

This deals with GROSS spinal range of motion, inability to ambulate and head protruding off the examination table. Also, how can this NOT BE SEEN by Dr.Mancall- a surgeon since 1959. The presentation on 7-6-96 is clearly abnormal and supported by the testimonial evidence which is unrefuted by the respondents.
Book II-A33-A39

3. Dr.Waterman's testimony has controlling effect because it spells out treatment in great detail and further supports the OBVIOUSNESS criterion of Brophy.

Brophy v. Brizuela 358 Pa. Super 400, 405, 517 A.2nd, 1293-1296 (1986)

"I had the opportunity of seeing Mr.Maresca at UCONN Division of the Rheumatology Clinic on 9-8-1999. As you know, Mr.Maresca is a gentleman with a great deal of musculoskeletal complaints. In addition, he has a history of inflammatory bowel disease."

Book II-A. 68 and A. 69 describes the finding of Ankylosing Spondylitis (AS) and the treatment of sulfasalizine or an anti-inflammatory protocol.

TRIAL EXH. 96 This is not grey area testimony.
It is clearly within the reasonable man/person doctrine. Dr.Waterman's conclusion removes the question that treatment for the incurable disease Ankylosing Spondylitis was not necessary. The need for an anti-inflammatory protocol establishes the causal connection between the inflammatory bowel disease of Crohns and the exacerbation of the Ankylosing Spondylitis (AS) . A. 57-A. 71 of Book II A108-114 of Book II

4. Politz is controlling precedent if the Pa. law stare decisis doesn't deal with AS. Also, SSA law is a more controlling precedent because the Penn.law doesn't cover (AS)

SSA. DI 280 40.001 MINE 416.99c
[Medical Improvement Not Indicated for Ankylosing Spon.]

A grey area implies structure. Metzelfelt does not have rule formulations making it unstructured and not a grey area. In addition, the MINE definition under the SSA is controlling precedent federally which is widely accepted. For example, The United States Patent Office requires unobviousness but limits the area to novelty, drawings, prior art references, specimens...37CFR Par. 1.71 onward. Many examples of art in the preferred mode are on file. The 5th Circuit defines the disease Ankylosing Spondylitis and is the only circuit to do so excepting the SSA law:

" He was diagnosed as suffering from Ankylosing Spondylitis, a chronic, progressive and debilitating disease which fuses the spine and causes rigidity of the cervical, thoracic and lumbar vertebrae. "

Smith v. United States Railroad Retirement Board 95-60433 United States Court of Appeals-5th Circuit by Chief Judge Politz, Davis, Garza

5. Constitutional rights control with an undefined law. Felder v. Casey, 487 U.S. 131, 138 (1988)

This case establishes that the Supreme Court will protect an individual's federal rights from being limited by local practice. Contrast the Metzelfelt criteria to the unobviousness in the patent law which requires novelty, a specification, drawings, specimens

A jury never rendered a decision as the trier of facts in this case. In fact, huge bodies of testimonial evidence by Diplomate Deng-Acupuncturist, Dr.Waterman-Rheumatologist, Dr. Kellman-Internist and the plaintiff at trial were never cited by the DC Trial Court. Whatever omissions of critical testimony occurred in the rendering of the DC Trial Court opinion of 6/04 were carried forward as omissions by the 3rd Circuit Court of Appeals. Neither Court supported an election between Metzelfelt or Brophy.

6. Substantial grounds not previously presented are the new findings of skeletal pelvic and sacroiliac total joint destruction 5-31-05 x-rays of Dr. Lee MD, PhD which relates to the x-ray of the sacroiliac joints opined by Diplomate Felder. APP. 3rd Cir. Docket 47 Book II- A. 90--Dr.Felder-expert opines on sacroiliac joint

The implications are that the sacroiliac joint and pelvic area could have been treated with early detection by Dr.Mancall in his 12-5-96 exam. This aspect is wholly supported by the facts of Diplomate Deng's testimony on the difficulty in ambulation and getting on/off the examination table. A.33-9

7. The Trial Court addressed incurable diseases in its 5-7-04 opinion rendered with prejudice and changed to without prejudice on 8-30-04-- a time too late to do anything further because the matter was in the Appellate Court.

" However, in medical malpractice actions involving incurable diseases, because a causal connection between the care provided by a physician and resulting injury can often not be established to such a degree of medical certainty, the Court requires only that the treating physician's negligence was a substantial factor in causing Plaintiff's injury.

Joyce 694 A. 2d 657 In such cases, we require only that the treating physician's negligence was a substantial factor in causing plaintiff's injury. Accordingly, if the plaintiff has proven that the physician's breach increased the risk of harm, then there is sufficient evidence to overcome a motion for judgment as a matter of law. Id.

Montgomery v. S. Phil Medical Group Inc.-441 Pa. Super 146, 656 A 2nd 1395 (1995), Clayton v. Sabeh 406 Pa. Super, 335, 594 A 2nd 365 (1991) The expert in cases of this nature has been permitted to testify under the relaxed degree of certainty enunciated in Sec. 323 (a) of the Restatement (2nd) of Torts, that the defendant's failure to exercise reasonable care in the diagnosis & treatment was a substantial factor that increased the risk of harm. Eaddy 694 A2nd at 642 citing Billman, 761 A 2nd 1212

Dr. Felder-Neurologist-Expert articulated that symptomatology is the only aspect that can be treated for an incurable illness; such as, Ankylosing Spondylitis.
A113 P. 110 ln. 20
"It's treatment of symptomatology". (Expert -Felder)
P. 85 ln. 16 [also see A.67 to A69 for discovery date of AS]

Q. Do you agree that chronic tension headaches was an appropriate diagnosis?
A. Yes, it is a diagnosis of one of Mr.Maresca's symptoms.
(Expert-Felder on A. 113 Pg. 85 ln. 16 ; A135-43
Dr.Mancall's exam fails the scientific method of a hypothesis, conclusion and inference on 2 of 3 of the classic skeletal deformations demonstrated to him.

Diplomate Felder articulated that the patient had the tremendous risks of Ankylosing Spondylitis from 12-5-96 (date of Dr.Mancall's exam) to 9-15-99 the date of discovery of Ankylosing Spondylitis)
A. 112 Pg. 65-66 through A. 114

The Plaintiff's "Request for Reconsideration" in the DC Docket 87 contains an extensive discussion of the inflammatory implications of Ankylosing Spondylitis opined by the Petitioner's Expert-Diplomate Felder which connects to the overall fact witness testimony of Diplomate Deng-Acupuncturist, Dr.Waterman-Rheumatologist at the UCONN Medical School and Dr. Kellman MD-Internist and Treating Physician in the post-period of the 9-15-99 discovery of the disease Anklylosing Spondylitis. see Book II

Judge Legrome Davis changed his original opinion from a dismissal with prejudice to a dismissal of the case WITHOUT PREJUDICE based upon a lengthy deliberation of this Reconsideration document by 8-30-04. The Court indicated that it was too late to act because the case had been filed with the 3rd Circuit Court of Appeals.
[Book I -A.1]

7. Plan for a New Trial:

Make the same presentation but continuation in part of expert testimony of Diplomate Felder to clarify any areas where the court has further questions and/or explain in greater detail the connection between Dr. Mancall and pain and suffering in the intervening period of 12-5-96 through 9-15-1999- the discovery date of AS by Dr. Waterman of UCONN MEDICAL SCHOOL. The connection is basically that the patient wasn't treated or monitored for AS .I f the patient had been monitored, there would 've been less pain and suffering, as well as the chance for a remission and salvaging of the sacroiliac and pelvic joints - later totally destroyed by the 5-31-05 x-rays of Dr.Lee MD, PhD. At a new trial, Dr.Mancall's experts would be examined regarding their agreement or not with the 11-22-02 expert letter of Diplomate Felder MD-Neurologist . A.135 to A143

The Petitioner's expert-Diplomate Felder would be asked to critique on the incremental damages regarding the total destruction of the sacroiliac and pelvic joints which were in place substantially during Dr. Mancall's 12-5-96 exam. Dr.Lee's 8-9-2001 single AP view of the pelvis shows fusion of the sacroiliac joint symmetrically- unchanged since the prior lumbar spine series of 9-9-1999. A. 159

Dr. Mancall would be asked about circumstances surrounding the neurology award and any representations by him or his institution to the President of the American Academy of Neurology .

Damages: The damages are the late discovery of Ankylosing Spondylitis on 9-15-99 instead of 12-5-96 when the disease was present by Diplomate Felder's expert testimony. In addition, the sacroiliac and pelvic joints were totally obliterated by 5-31-05 and the patient is in the advanced stages of Ankylosing Spondylitis with kidney-proteinuria issues, as well as more chronic inflammations by the blood chemistry. The expert testimony of Diplomate Felder does concur that the first 10 years of the disease are important with respect to subsequent outcome. A. 113 Pg. 114 ln. 21
The patient had quality of life degradation, as well as patent interference with an in force patent 5,075,857 of 12/91 for Earthquake Monitoring during the period of non-discovery and the pendency of the 5 years of this litigation. This patent is prior art to at least 3 or more citations including fluid system art, an electronic rate meter controller and a networked agricultural monitoring system.
The Earthquake Monitoring Device has been acknowledged by the Cornell Research Foundation, the University of Maryland at College Park and the "employer at will" in an 8-1-1996 acknowledgment of the patent by the American Institute of Certified Public Accountants.
[5,574,657; 5,475,614 and 5,260,875]

ATTESTATION
UNDER RULE 44

This Petition for a Rehearing is presented in good faith by the Petitioner with no intention to delay the proceedings. The presentation highlights circumstances of a substantial or controlling effect and other substantial grounds not presented previously or not delineated or claimed with the level of particularity set forth in the current submission.

The grounds set forth explain the areas of the law which provide little or no rule structure as against the presentation of the evidence which is unmistakably clear and unambiguous, as well as new information which casts an increased exigency to the claimed injuries of the Petitioner .

Joseph A. Marasca

10.26-06